MEDICAL AND SURGICAL REPORTER

No. 1670. PHILADELPHIA, MARCH 2, 1889. Vol. LX.—No. 9.

CONTENTS:

LECTURE.
Jackson, Edward, A.M., M.D., Philadelphia, Pa.—Failure of Vision in Old Age....257

COMMUNICATIONS.
Long, J. W., M.D., Randleman, N. C.—Practical Aseptic Surgery....261
Baum, Charles, M.D., Phila., Pa.—Case of Meningocele.265
Scott, T. Y., M.D., Bentleyville, Pa.—Case of Sub-spinous Luxation of the Head of the Humerus....266
Harvey, Thomas W., M.D., Orange, N. J.—Acetized Cotton....266

SOCIETY REPORTS.
Philadelphia County Medical Society....267

REPORTS OF CLINICS.
Bellevue Hospital, New York....273

NEW YORK CORRESPONDENCE.
Treatment of Club-foot at the University Medical College.—A Good Caustic for Cancer.—Clinics of Drs. Bull, Thomson, and Winters....274

PERISCOPE.
On Gas-cysts of the Vagina.—Friedreich's Disease, 276. Bacteriology and Antisepsis of the Conjunctival Sac.—A New Deodorant, 277. Gonorrhœal Infection.—Absorption of Tissues of the Mouth from Pressure....278

EDITORIALS.
Extirpation of Tumor of the Bladder....279
Expulsion of Foreign Bodies from the Alimentary Canal.—Death Caused by Cocaine-Habit.—Camphorated Naphthol....280
Imposing on a Physician....281

EDITORIAL NOTES.
The Philadelphia County Medical Society.—Publishing Lectures without Permission of the Author....281

BOOK REVIEWS.
Seiler; Handbook of the Diagnosis and Treatment of Diseases of the Throat, Nose and Naso-pharynx....282

PAMPHLET NOTICES.
Rogers; Functions of a School for Feeble-minded.—Oliver; New Series of Metric Test-Letters.—Solis-Cohen; Cautatory Paresis.—Solis-Cohen; Syphilis of the Larynx.—Crothers; Inebriate Asylums.—Meier; Why Electrolytic Treatment of Stricture Does Not Succeed in all Hands....282

LITERARY NOTES....282

CORRESPONDENCE.
Are Medical Witnesses to be Subjected to New Tests?—Treatment of Ichthyosis, 283. Removal of Gunpowder from the Face.—Good Form in Professional Cards, 284.

NOTES AND COMMENTS.
Disposal of Garbage, 284. Ergot in Facial Neuralgia.—Peru Balsam in Buccal Leucoplakia.—Catarrhs of Mucous Membranes.—Gonorrhœal Orchitis, 285. Effect of Sulphonal.—Fatal Case of Corrosive Sublimate Poisoning.—Eschscholtzia Californica.—Gift to the Presbyterian Hospital, 286. Minnesota Medical Act.—American Medical Association, 287.

NEWS AND MISCELLANY....288
OBITUARY.—William Weightman, Jr., M.D....288

LECTURE.

FAILURE OF VISION IN OLD AGE.[1]

BY EDWARD JACKSON, A.M., M.D.,
PROFESSOR OF DISEASES OF THE EYE IN THE PHILADELPHIA POLYCLINIC.

It is a general law that the more highly differentiated or developed an organism or an organ, the more liable it is to injury by violence from without, or defect of nutrition from within. From this liability the delicate and complex visual apparatus is not exempt. It is universally understood that some sort of loss of visual power is a necessary condition of old age; but few appreciate how often remediable conditions are taken as part of the inevitable, and submitted to without any attempt to get relief.

The conditions causing impairment of vision coming on with age might be grouped under two heads: physiological, those arising in what must be regarded as a strictly normal course from development to dissolution; and pathological, or those diseases to which age renders the eye especially liable. But between the two groups no hard and fast line can be drawn. There are conditions, such as senile nerve-atrophy and cataract, which, though commonly classed with diseases, are so closely allied to the normal senile degenerations, that the placing of them in the one group or the other would seem to depend mainly on the age at which they occur, or the relative advancement of other processes of bodily decay.

Failure of Accommodation.

Among physiological conditions, most important is failure of accommodation, beginning in infancy and almost complete at the period when other senile changes are fairly begun. Primarily the loss of power to focus the eye for near objects depends on increased rigidity of the crystalline lens. The lens, jelly-like and extremely elastic in infancy, becomes progressively harder and

[1] One of the Tuesday Evening Lectures, delivered at the Philadelphia Polyclinic.

less elastic year by year. So that while during adolescence the ciliary muscle actually increases in strength, its power of changing the shape of the crystalline lens and rendering it more convex steadily diminishes. As the process continues the near point of perfect focussing, and distinct vision, recedes; until between 40 and 50 years, in the normal course of the change, ordinary close work, such as reading, writing, sewing, etc., is interfered with, and *presbyopia* is said to begin. Yet even when this occurs there may still be no diminution in the muscular power brought to bear on the crystalline lens, but simply an increased resistance to any change of shape. Later when the power of accommodation has been still farther diminished, so that what remains is of but little practical importance to its possessor, and he comes to rely on glasses for any change of focus, the ciliary muscle often undergoes atrophy, caused or accelerated by disuse; and the remnant of accommodative power is entirely lost. After this failure, which for all emmetropic and hyperopic eyes has necessitated the wearing and frequent strengthening of glasses, is complete, there can be no farther loss of sight from this source. It is popularly regarded as remarkable that a person of eighty or ninety should be able to read with the same glasses as he wore twenty or thirty years before; but really the failure that glasses were sought to make good, is commonly complete at sixty, and unless the eye is changed in some other respect, no other glasses could be so satisfactory.

Senile Ametropia.

The loss of the power of accommodation does more than simply interfere with the seeing of near objects. While emmetropia is the standard aimed at in the development of the eye, few eyes accurately attain it. In nearly all there is present a perceptible amount of ametropia, usually in the direction of hyperopia; which the power of accommodation enables one to correct. This power being gone the ametropia becomes absolute, and distant vision also becomes imperfect. Hence the large majority of persons, through changes strictly physiological, suffer some failure of vision with age. But this failure can in a manner be compensated by the use of glasses.

The same compensation is available in the case of ametropia not formerly present and unmasked by loss of accommodative power, but arising from senile changes in the form or refractive power of the cornea or lens. Such ametropia generally takes the form of hyperopia, the so-called "H. acquisita"; but in quite an important class of cases there is an increase in the refractive power of the lens leading to myopia. These latter are the cases of "second sight." After having been compelled for years to wear convex glasses for near vision, they discover that they can again read with weaker lenses, or without any such aid at all. But this does not come through any recovery of power to change the focus of the eye, but through a gradual shifting of the point for which the eye is adjusted, from a distance to somewhere about the point at which objects are commonly held for near vision. The adaptation for near-seeing is gained by loss of distinctness in far-seeing. These same senile changes of the crystalline lens occasionally give rise to considerable degrees of regular astigmatism; and very generally in their more advanced stage cause irregular astigmatism. These same changes, carried but a little farther, result in opacity of the crystalline lens, or cataract.

Cataract.

This condition is of importance, not only because it is common and often causes the loss of all useful vision, but especially because its management often requires the reversal of the rule which applies to all other conditions likely to cause blindness. In other conditions treatment does most good, or only does good, when commenced at the earliest possible moment. In cataract radical treatment can be resorted to only after a longer or shorter period of delay. If, as happens not rarely, a diagnosis of cataract is made when the failure of vision is really due to something else, the patient is likely to be advised to enter upon a course of waiting which never can do any good, and that may consume the precious time, during which alone therapeutic measures could have been resorted to with any chance of benefit. On this account, I hold that every one offering himself to the people as a general practitioner of medicine or surgery, and undertaking to give any opinion as to a failure of sight, should be able to recognize with certainty whether, in any given case, cataract be, or be not, present to such extent as probably to cause the given impairment of vision.

Among methods that may be employed for the recognition of cataract, that of simple inspection, or inspection under the most favorable conditions, called *oblique illumination*, may be mentioned, only to state that no reliance whatever should be placed

upon it. The experienced ophthalmic surgeon knows that while in some cases he can recognize cataract in this way, that any senile eye with a dark enough choroid, and large enough pupil, will present a striking appearance of opacity of the lens, although the lens may be absolutely normal and transparent. So that the largest experience will not enable him to judge whether it really is a case of cataract or not. Again, there are some cataracts, so-called black cataracts, in which the appearance of the pupil is quite normal. And even in ordinary forms of cataract, if the pupil be small and the opacity not immediately beneath the pupil it may not, in this way, be possible to recognize its presence.

The diagnosis of cataract is generally to be made with the *ophthalmoscope*. But by ophthalmoscope I do not mean any elaborate or high-priced instrument. The cheapest, the common "Liebreich" form, which cannot be spoken of as *good* for any thing else, answers this purpose as well as the most costly. The perforated concave mirror commonly used for illuminating the ear, nose, or throat, answers admirably; or, lacking all these, any piece of looking-glass with a little opening scratched in the silvering will be found quite satisfactory. Throwing the light into an eye with the ophthalmoscope, held ten or twelve inches distant, and placing his own eye at the aperature in the mirror, the observer sees the pupil of a normal eye occupied by a uniform red glare, paler in persons having a light choroid, or when the optic disc comes opposite to the observer, and more dusky as the choroid is darker. When however cataract is present, this red glare from the fundus of the eye is interrupted. If the cataract be advanced toward maturity, no red light from the fundus is perceived by the observer; but if even the smallest speck of lens substance has become opaque, it will appear as a black spot very noticeable against its brilliant red back-ground. Specks of opacity in the cornea, or upon the lens capsule, may cause the same appearance; but if the observer will move his position up and down, or from side to side, specks in the lens will seem to move across the pupil in the same direction as he moves, those in the cornea will seem to move in an opposite direction, and those on the lens capsule will appear to remain stationary. In the very few cases in which the ophthalmoscope does not entirely settle the diagnosis as to cataract, the *catoptric test* may be resorted to. In it we look for the little and rather faint inverted image, formed by the posterior surface of the normal lens, of a candle-flame held before the eye. We recognize this inverted image in this way. The cornea always gives us a bright erect image of the flame; and the inverted image we seek is situated on the opposite side of the pupil, and on moving the candle, while the corneal image moves with it, the image in question moves in exactly the opposite direction. Of course any opacity of the lens or its capsule prevents the formation of any such image.

You must not regard the certain recognition of the presence of lens opacity as completing the diagnosis of cataract. It only begins it. Many old people have some opacity of the crystalline lens, whose impairment of vision is due, perhaps entirely, to other causes. For cases occur in which, with very marked opacity of one portion of the lens, other portions are so little affected that the vision remains normal, or very nearly normal. But on the other hand, when the lens by its opacity gives evidence of damage by imperfect nutrition, it does not generally suffer alone. As a rule other parts of the visual apparatus suffer with it; and to their impaired function the lowering of vision may be due, quite as much as to cataract. So, while it may be quite unjustifiable to make a diagnosis of cataract when there is no cataract, it may be almost as bad for the patient to rest on the diagnosis of cataract, even though it be present, if along with it some other unrecognized lesion exists, which is equally or to a greater extent the cause of the impairment of vision. One other point about cataract is to be remembered, namely, its extreme frequency. After a certain age a majority of eyes present some lens opacity; and in extreme old age it is quite general; but the majority of persons die before the opacity has involved enough of the lens to deprive them of useful vision.

Glaucoma.

An affection frequently confounded with cataract, and always with most disastrous results, is glaucoma. In it the pupil is commonly rather large, and the lens looks gray, or greenish and partially opaque, to simple inspection, even though it is perfectly clear. The essential fact of the disease is increased tension or hardness of the globe. It occurs after middle age; and this has been ascribed to the increased size of the lens, which continues to grow throughout adult life. It is supposed that the lens pressing on the periphery of the iris hinders the out-flow of fluid from the eye, and thus causes the

increased tension. The course of the malady is invariably, unless checked by treatment, toward absolute blindness, usually with great pain in and about the affected eye. But its progress is often very insidious and deceptive. Exacerbations occur during which the sight grows suddenly worse, followed by partial recoveries during which some of the visual power is gradually regained. The patient is inclined to hope that each "relapse" may be the last, and may be followed by more complete recovery; and fails to realize that each is a positive advance of the morbid process covering ground never to be regained, and with an ever increasing tendency toward accelerated movement. These exacerbations are commonly attended with pain and hyperemia of the globe, which ought to distinguish the affection absolutely from cataract, but which are too often ascribed to "neuralgia" and a "simple inflammation" of the eye-ball. Glaucoma is not a very common affection; but its strongly malignant tendency gives it a great claim on the attention of the general practitioner.

Passing over certain other pathological conditions which might claim notice here, such as albuminuric retinitis, and a form of chorio-retinitis that might well be designated as senile, as of comparatively less importance, let me call your attention especially to

Senile Amblyopia and Atrophy of the Optic Nerve.

Of course, I use the term amblyopia in its modern sense, to designate imperfect vision, which cannot be accounted for by any fault of refraction, or pathological process making itself manifest in any other way. The impairment of function must in such a case involve some portion of the nervous apparatus concerned in the act of seeing. Amblyopia occurring in old people is often to be regarded as strictly physiological, as merely a part of the general diminution of capacity of the organism to respond to external stimuli, which constitutes a true decline of life. Often the amblyopia is accompanied by or depends on a lessened blood-supply of the parts, which is shown by a pallor of the optic disc; and in many cases this local anemia is but part of a lessening of the general blood-supply, another kind of vital decline. But marked amblyopia may exist without perceptible local anemia, and a very noticeable pallor of the disc is not incompatible with perfect acuteness of vision. When both pallor of the disc and impairment of vision are especially well-marked, the case may be regarded as one of optic atrophy. In cases of atrophy, however, there is also contraction of the field of vision. In senile atrophy, this contraction is concentric and most regular, and is especially great for color vision, red and green being distinguished only in the immediate vicinity of the fixation point.

A point which I wish in this connection especially to impress upon you is that you should not conclude that any given case is one of merely senile, or irremediable amblyopia, or nerve atrophy, until all other possible explanations of it are proved unsatisfactory. My experience indicates that in old people with inferior blood-supply, with diminished power of resistance, with lessened capacity for repair, the nervous portion of the visual apparatus is especially susceptible to the actions of certain substances that influence it injuriously, such as tobacco, lead, quinine, large doses of the bromides, etc.; and that these agents may produce amblyopia or atrophy, even though they are taken only in amounts that have previously produced no injurious effect whatever. For instance, I have now under observation a man, 60 years old, who had used tobacco very moderately, and only a little alcohol occasionally, ever since he was a boy, and who is using less now than in earlier years. His sight had been failing for six months, and was less than half the normal. Stopping the tobacco and alcohol, and taking full doses of strychnia gave him full vision within a month. Had I rested in a diagnosis of senile change, probably neither my patient nor I would have been the better off for our coming together.

—The *Medical Press and Circular*, Feb. 6, says: Fears have been expressed lest the Paris schools should be overrun with foreign students, and it would even seem that endeavors have been made to impose certain onerous restrictions on their attendance. A recent number of the *Revue Scientifique* contains a very eloquent protest against so unworthy a sentiment, especially on the eve of an international exhibition. The prestige of the ancient Faculty of Paris would suffer sadly were foreign visitors to be driven away, and its influence as an intellectual centre diminished. University teaching in France is practically free to all comers, and it is one of its most noble attributes. It is satisfactory to find that the *Chauvinists* are not likely to have it all their own way.

COMMUNICATIONS.

PRACTICAL ASEPTIC SURGERY.[1]

BY J. W. LONG, M.D.,
RANDLEMAN, N. C.

Mr. President and Gentlemen: On this occasion I hope to speak not so much *to* you as *through* you to the great body of patient toilers throughout the South. Southern doctors are beset by many trying difficulties. In the first place, most of them are dependent upon their practice for a living, while many have large families to support; besides, those of us who do not live where we are accessible to a drug-store are compelled to furnish our own medicines and surgical supplies. Add to these difficulties broken-down health—which is often the case—from overwork and exposure, and, I am sorry to say, sometimes from dissipation, and is it any wonder that the average Southern doctor buys so few new books and periodicals and so seldom reads them when he does get them? The subject which I shall endeavor to present to you to-day has invited so much speculation and given rise to so many varying methods, each claiming to be the right one, that our minds have become confused and we overlook the principles involved by considering the hypotheses and paraphernalia incident to the subject. If I can even to a small extent strip this great question of some of its extravagances and impracticabilities and present it to you in a practical everyday form, then I shall count myself most happy.

We all know that in these latter days the *technique* or management of accidental and surgical wounds is entirely different from what it was one or two decades ago. Formerly the operator expected suppuration; now he is disappointed if it occurs. Then surgical fever followed almost every operation as a matter of course; now its presence indicates some defect in the management of the wound. Aseptic surgery has come to be the order of the day, and it simply means surgical cleanliness as applied to the treatment of wounds. Aseptic surgery has made dangerous operations safe, and legitimized many heretofore unjustifiable procedures. It is the outcome of common observation that devitalized animal tissues when brought under favorable conditions putrefy. These favoring conditions are warmth, moisture, and certain micro-organisms. The absence of any one of these conditions will prevent the fermentive changes which in the living animal result in suppuration and septicæmia. Now I am not here to champion asepsis, nor to dispute with any one the validity of its principles, for I consider that these have already been established upon an immutable basis; and he who does not believe in aseptic surgery must necessarily believe in septic surgery. Notice, please, that I did not say *anti*septic but *a*septic; for antiseptics are only methods, while asepsis is a science involving great and unvarying principles: the one may change, the other never. Carbolic acid and corrosive sublimate may be forgotten, iodoform may be relegated to the realms of obscurity, but surgical cleanliness will ever be counted the greatest safeguard to life and health that man has yet devised.

The object of this paper is purely practical, and the hope is earnestly entertained that aseptic surgery may be set forth in such a light, stripped of all technicalities as well as of all unnecessary expense, that any regular doctor possessed of a fair knowledge of anatomy may at comparatively small cost fit himself to do in an aseptic manner all the operations which occur in every-day practice. After having once tried aseptic surgery and mastered its principles, I am sure no conscientious man will ever go back to the old ways of long finger-nails and rusty instruments.

To this end I have devised two bags, the smaller of which is my daily companion, the larger being used only in the more important operations. Prof. Gerster presented to the New York County Medical Society a bag to be used in "surgical emergencies," and while it is a capital thing, it is not adapted to the everyday work of the average practitioner. My larger bag is somewhat like his. I have been led to the construction of these bags by the repeated annoyance which arises from not being prepared to do the operations, great and small, that constantly come up in my practice. Not only has this been true of myself, but I know numbers of good men who believe in asepsis and antiseptics, and would like to do their operations aseptically, but they are not prepared to meet the emergencies as they arise, and they go along in the old slip-shod way. Furthermore, they are deterred from trying to get ready by the controversies and mystery which surround the subject and the supposed great expense of the necessary appliances. As a matter of fact, I do not know of one man in fifty who

[1] An address delivered before the Southern Surgical and Gynæcological Association, Dec. 4, 1888.

is prepared at any moment to amputate even a finger, or do a herniotomy, or any other operation in an aseptic manner.

The rules and formulæ of aseptic surgery are simple but comprehensive, and may be briefly stated as follows:

The proper cleansing of the surgeon's hands and arms and the parts to be operated on deserves the first consideration. The surgeon's coat should be removed, his sleeves rolled above the elbows, the finger-nails carefully pared and all dirt removed from under them by means of a sharp-pointed pen-knife. The hands and arms should then be scrubbed and soaked in hot water and soap. Lye soap is preferable because of its solvent properties. The hands ought to be kept in the water for at least five minutes, that the hard places and crevices may become thoroughly softened and cleansed. A stiff nail-brush is indispensable in cleansing the hands. After this the hands and arms should be placed for one minute in a solution of corrosive sublimate, 1 to 1000. During the operation a basin containing a similar solution is placed convenient to the operator, who dips his hands into it whenever he chances to touch anything that has not been sterilized, as a chair, his nose, a sponge picked up from the floor, etc. This same care of the hands is required of all the assistants. Surgical cleanliness means more than some people imagine. I remember seeing a doctor, who does a large amount of surgery and who professes to believe in and practice antisepsis, apply an ointment to the lids in a case of syphilitic conjunctivitis, then examine and make application to a case of hemorrhoids, catheterize a patient, and finally operate for double pterygium—all without washing his hands either before, during, or after treating these several cases. As Gerster says, "the new surgery of cleanliness does not tolerate pretense and imposition."

If possible, always have the patient bathe and change his clothing before an operation. When on the table the parts to be operated on must be carefully cleansed with hot water and soap, shaved, and finally washed with sublimate solution, 1 to 1000. Towels wrung out of a warm sublimate solution should be arranged around the field of operation.

It is impossible to do work aseptically with instruments that can not be rendered aseptic. The ingenuity and workmanship displayed in complicating instruments is simply wonderful—double joints, screws, rough handles, and every other device imaginable to make an instrument difficult or impossible to be cleaned. I am glad to note that modern surgery is demanding instruments more simple in construction, the revolution exhibiting itself in open joints and hard-rubber handles. An instrument should have as few joints as possible; most jointed instruments can be made with one joint, and this must be an open joint, either like the American bullet forceps, which have the French joint, or the Jones joint. Very few instruments indeed can not be made to come apart easily. Toothed instruments should have coarse teeth, with the angle between the teeth obtuse and rounding, so that all particles of matter may be readily dislodged by a stiff nail-brush. Those instruments not having solid metal handles should have baked-rubber handles. Such handles will withstand the effects of boiling water, which is the best medium for cleaning instruments. Wooden handles or rough handles are entirely unsuitable and should be discarded. Even the name of the manufacturer should not be stamped on an instrument. The Sims' dull curette is a beautiful example of an aseptic instrument, while the sharp curette is a typical example of a non-aseptic instrument. Horn handles like this scalpel are objectionable, as hot water causes the sides to spring away from the metal shank, leaving crevices in which particles of matter may lodge; we can never be sure they are clean. The Volkmann scoop is also perfectly aseptic, while the periosteal elevator is "a thing of beauty and a joy forever." These instruments were selected at random, and presented simply to show the difference between the perfect and faulty. I have been thus careful to particularize concerning the make-up of instruments for the reasons given above, and the additional fact that there is not a single pocket or operating case on the market, so far as I know, which meets the requirements of modern aseptic surgery. Every surgeon should select each individual instrument—don't buy anybody's "case," and see to it that in every respect each one is genuinely aseptic.

The care of instruments is an important item and has given me much concern. Half an hour before an operation they should be placed in a five per cent. solution of carbolic acid. For small operations a shorter time and a three per cent. solution will do. Knife blades remain in the solution only a few minutes, as the acid dulls

the edge. Immediately after an operation place the instruments in a pan and pour very hot, even boiling, water over them. They should then be scrubbed thoroughly with soap and a brush, and dropped back into the carbolic solution, from which they are taken and dried with a soft cloth. It is very necessary that all toothed instruments be carefully brushed with a stiff nail brush in order to remove particles of blood and *débris* which invariably lodge between the teeth. For transportation instruments should be wrapped in a clean towel, or placed in canvas case, as either can be washed, but a leather case can not be washed and causes instruments to rust. No rust speck should be tolerated. The rust must be removed or the instrument laid aside. For permanent keeping a dust-proof drawer or case in a dry room is the best place to prevent instruments from rusting.

I am constrained to specify the care of catheters, because of the imperfect manner in which they are usually cared for. Before using, the cleansed catheter should be placed in three per cent. carbolic solution; a 1 to 1000 sublimate solution may be employed for rubber catheters. In either case, transfer the instrument to a solution of common salt 6 to 1000 (heaping teaspoonful to the quart of water, previously boiled), after which anoint them with iodoform ointment (gr. viii to ℥i). After being used in a septic case soft rubber and woven instruments should be destroyed. To cleanse rubber catheters, wash them in hot water and soap, and flush by means of a small syringe; then wash and flush in a five per cent. carbolic solution. Metal catheters can be properly cleaned only by prolonged boiling (an hour), or by passing through an alcohol flame until all smoke and steam cease to issue from them. An observance of these precautions will greatly lessen the number of cases of urethral fever and catarrh of the bladder.

If we could always have our hands, instruments, the parts to be operated on, the atmosphere, etc., in the ideal aseptic condition, there would be no need of germicides; but, unfortunately, we can not be sure of this happy condition. Therefore we resort to the chemical antiseptics, by means of which we keep a wound aseptic, or render it so by sterilization.

Antiseptics.—For irrigation, disinfecting hands, preparing sponges and gauze corrosive sublimate is the best and most convenient germ-killer. For the hands, arms, and the parts to be operated on, solutions of the strength of 1 to 1000 are necessary; while for irrigating ordinary wounds solutions of from 1 to 2000 to 1 to 5000 are strong enough. Irrigation of the greater cavities require the solutions to be of only 1 to 8000 to 1 to 20000 strength. The following formula will answer every purpose:

℞ Corrosive sublimate . . . . . ℥i
Water . . . . . f℥ii

M. S. Teaspoonful to one pint of water = 1 to 2000.

Some add twenty grains of common salt to the above formula, which prevents the mercury from decomposing so soon. Tablets of corrosive sublimate containing the proper amount to be added to a pint of water may be purchased from any manufacturing chemist or large dealer. They are more convenient, but more costly than the salt prepared as above. In all solutions boiled water is preferable, but not indispensable, in the majority of instances.

For disinfecting instruments and keeping sponges aseptic, carbolic acid excels any known agent. A five per cent. solution is made by thoroughly mixing one ounce of the acid with one and one quarter pints of water; a three per cent. by adding one ounce of acid to two pints of water.

The Thiersch solution consists of boracic acid ʒi; salicylic acid gr. xv; water Oi. This solution may be used with impunity in the abdominal cavity or elsewhere, as it will cause no irritation.

No surgeon can afford to be without iodoform. Its desiccating properties render it invaluable in the treatment of the vast majority of wounds, both accidental and surgical.

I have given but a few of the well known germicides, for the reason that if we thoroughly understand the use of a few they may be made applicable to every case, and such knowledge is preferable to having an imperfect knowledge of many. Besides, it relieves the mind of the tedium and strain incident to frequent changes; for when one habituates himself to the use of any particular thing, its application becomes a matter-of-course and requires little thought.

Sutures.—Silver wire may be kept wrapped in protective or in a metal cylinder. The cylinder is costly and not indispensable. Silk may also be kept wrapped in the protective. Both silver and silk are rendered aseptic by placing them in a three to five per cent. carbolic solution for half an hour, or by boiling for an hour. Cat-gut is made

aseptic by soaking in the so-called oil of juniper berries[1] for twenty-four hours, then transferred to ninety-five per cent. alcohol; or it may be kept in the oil indefinitely. The bottle contains spools holding gut of several sizes, the ends passing through a perforated stopper, and any desired amount may be drawn from the bottle without removing the spools.

The best drainage tubes are of soft black rubber, with a lumen of one-sixteenth to one-half inch. These may be kept in a tightly corked glass jar dry, or in a five per cent. carbolic solution. Bone drains are useful in permanent dressings and are kept immersed in oil of juniper berries.

Dressings.—To prepare sublimate gauze, divide say twenty-four yards of cheese cloth into four pieces. Double each piece several times, and tie a string around it. Place these pieces in water with two pounds of bicarbonate of soda and boil for an hour or more. Then rinse the cloth through clear water and place it in a solution of corrosive sublimate, 1 to 1000. After twenty-four hours it may be wrung out and hung up in a dustless place to dry. For permanent keeping, either a stout jar, tight drawer, or a can with the lid held down by adhesive plaster will do. Excellent prepared gauze may be bought at about fifteen cents a yard; but it can be made by any one disposed to try at a cost of only about four or five cents a yard.

Iodoform gauze is made by sprinkling gauze freshly wrung from a 1 to 3000 sublimate solution with iodoform from a pepper box; Gerster's, or an ordinary tin box with perforated top, will answer.

Absorbent cotton can be purchased at small cost, or can be prepared in an emergency by dipping cotton batting in a fifteen per cent. boric acid solution (boracic acid ℥v, water Oii).

Protective is thin rubber tissue and costs about fifty cents a yard.

Bandages, both cotton and flannel, should be made from cloth previously treated as described for gauze. As a matter of economy a cigar-box will make an excellent bandage roller. Near one end pass a stiff wire through from side to side, and shape one end of the wire into a crank. Toward the other end of the box arrange three or four wires or rods so that the cloth will pass over and under them in succession. Every operating case should have one or two rubber bandages.

Sponges.—Florida sponges are cheap and are better than the fine silk ones. They are beaten well and washed to remove all grit; soaked for fifteen minutes in dilute muriatic acid; thoroughly kneaded in hot water and soft soap; rinsed through clear water till they loose the soapy feel; finally transferred to a five per cent. carbolic solution, where they may be kept indefinitely. After use in an aseptic case sponges are cleansed by repeated washings in warm—not hot—water, and immersion for one hour in 1 to 500 corrosive sublimate solution. Never use a sponge that has been used in a suspicious case, nor to dress a wound with; pellets of cotton are infinitely better and can be destroyed when once used. I have seen one little sponge do service in every case occurring in the practice of a distinguished (?) surgeon.

The irrigator is indispensable, the ordinary fountain syringe being one of the best for a surgical bag. On a pinch, the irrigating fluid may be poured from a pitcher.

In considering the types of dressings we will notice just three with their modifications; and these keep the wound in an aseptic state by desiccation, sterilization, or hermetical sealing of the surfaces, or by two or more of these principles combined.

Desiccation.—Small wounds, especially about the face and neck, may be kept aseptic by freely dusting them with iodoform, or equal parts of iodoform and subnitrate of bismuth. These drugs, especially the former, have the peculiar property of drying a wound by checking the secretions, while the secretions that do escape are rapidly desiccated to a pasty crust, which protects the wound from contamination by infectious substances and in turn is rendered aseptic by the antiseptic properties of the powders. When there is much oozing the parts should be dusted every half-hour until a crust has formed.

Sterilization.—By this is meant the moist dressing. The wound is gently packed with gauze squeezed from a fresh sublimate solution, 1 to 1000 to 1 to 2000. The field of operation and contiguous parts are lavishly padded with gauze and cotton previously treated as above, the whole being covered by a piece of protective, held in place by a roller bandage. This dressing will absorb discharges more readily than the dry dressing, and is applicable in cases in which we may expect profuse oozing or fear the drainage tubes will become clogged. When no

[1] In a private note from Dr. Squibb he says: "The best oil of juniper berries in the market is obtained by distilling the fresh twigs of a different variety of juniper from that which bears the berries."

impervious outer dressing can be had, the gauze may be kept moist by pouring a drachm or two of an antiseptic solution into it every half hour.

Desiccation and Sterilization.—These two types of dressing are happily confined and modified in the *dry dressing*, in which the wound and parts around are thickly covered with gauze and cotton, previously sterilized by chemicals. A few strips of iodoform gauze are laid directly over the line of incision to facilitate the drying of the deepest portions of the dressing. No protective is applied to the outside, as the free access of dustless air is necessary to hasten the drying process.

Schede's modification of the dry dressing.—The prime object in this dressing is organization of the blood-clot. Asepsis must be perfect. A piece of protective just a little larger than the wound is laid directly on the parts, and iodoform gauze thickly applied above this. No protective is used on the outside of the dressing.

Hermetical sealing of the wound.—I do not think any paper relating to the modern treatment of wounds complete that does not give credence to the hot water method, so ably promulgated by the late Dr. Varick. This is specially indicated in amputation wounds, and consists in applying water only a little below the boiling point to the freshly-cut surfaces until they are thoroughly glazed with a coat of albumin. This effectually occludes the mouths of all lymphatics and small vessels, including the capillaries, so that contamination is impossible. The parts are next brought together, and little dressing is applied. The success of this method is truly wonderful. Small wounds may be hermetically sealed by touching them with acetic acid.

(*To be continued.*)

A CASE OF MENINGOCELE.

BY CHARLES BAUM, M.D.,
PHILADELPHIA.

On September 18, 1888, I was summoned to attend Mrs. N—, æt. 37, American, of large frame, very fat figure, and nervous temperament, being in labor with her eighth babe.

Two abortions had occurred in her early married life. No history or evidence of syphilis could be elicited. At a preliminary visit she stated that in her former labors she had acted like a crazy person, screaming, pulling out her hair, striking her head and attempting to bite her attendants.

When I entered the room she was highly excited, walking the floor, wringing her hands and declaring she would "die this time." Her former children had been very large and forceps had been applied on one occasion to hasten delivery for the relief of nervous agitation.

Dilating pains had continued six hours. As the woman was in the act of placing herself in position for a digital examination, the amniotic fluid escaped with a gush. Upon examination, her pelvic diameters were found to be larger than normal, the os uteri was fully dilated and the finger came in contact with an elastic tumor, covered with the hairy scalp. Owing to obliteration of the usual fontanelles and sutures a right occipito-anterior position was determined by the relation of the ears to the swelling and the neck. The woman was at times entirely uncontrollable, but the labor pains were active and in two and a half hours the delivery was accomplished, manual assistance being demanded to liberate the shoulders and hips. Before the hips were delivered the child cried loudly. In deference to a superstitious notion of the mother, the extremely large male babe was not weighed, but was thought by the nurse to be about fifteen pounds; it surely weighed twelve pounds.

On the right side of its head was found an elastic, prominent tumor, which arose from the posterior fontanelle and extended along the sagittal and a portion of the lambdoidal suture. This entire region was bulging, while the edges of the occipital and parietal bones were everted about half-inch. Longitudinally over the prominence the measurement was 5¼ inches, transversely, 4¾ inches. Light was readily transmitted through the swelling. As the child grew, it was noticed that pressure upon the tumor caused drowsiness. In addition to this defect there was right sided scrotal hernia; otherwise, the child seemed healthy and natural in appearance.

To satisfy the demands of the parents, as well as to try the experiment, one gramme of potassium iodide dissolved in compound syrup of sarsaparilla and water was administered internally three times each day, and this was continued until the swelling was absorbed; locally, an application of ammonium chloride gr. xv, alcohol f ʒ j, was ordered to be made every six hours, but as was learned later, the parents made it every three hours.

By degrees the swelling disappeared, and on November 27, 1888, the bones were

united along the suture lines, there being, however, a general prominence, which has remained unchanged, over the region involved. Excepting slight constipation during the second week the child has remained perfectly well, never having displayed any nervous symptoms. At present it is teething easily, and was vaccinated January 24, 1889. He is large, fat, solid, bright, laughing and playful.

630 N. Broad St.

CASE OF SUB-SPINOUS LUXATION OF THE HEAD OF THE HUMERUS.

BY T. Y. SCOTT, M.D.,
BENTLEYVILLE, PA.

The reading of the report of Dr. Cate's case of sub-spinous luxation of the humerus, in the REPORTER of January 19, 1889, brings to my mind a similar case that occurred in my own practice, being the only case of sub-spinous luxation that I have met with in eighteen dislocations of the head of this bone. By referring to my note-book, I find the following particulars of the case, under date of Jan. 16, 1884:

Mr. J. C., æt. 70 years, a small man and very spare, apparently devoid of any adipose tissue, was thrown down while feeding his hogs by a large hog running against him from in front, tripping up his feet and pitching him forward, he alighting, with extended arms, upon his palms, while his feet were elevated in the air upon the back of the hog. I saw him within four hours after the happening of the accident. I found him sitting in a chair with the right arm resting upon pillows, and extending forward, slightly downward, and very slightly outward, the forearm flexed at a right angle with the arm. He was suffering much pain in the right shoulder. Examination of the shoulder showed no contusion or swelling, other than a hard rounded prominence on the posterior surface of the scapula, below the spinous process; absence of the head of the bone from the axilla, and a depression beneath the anterior portion of the acromial process. The sub-spinous tumor was firm, rounded and resisting, and its movements, in obedience to rotation and other movements of the humerus, were, owing to the marked scarcity of adipose tissue, very perceptible both to the eye and the finger.

In this particular case the prominence of the coracoid process was very marked.

Repeated attempts at reduction, both by manipulation and extension and counter-extension with the heel in the axilla, failed, but it was very readily accomplished by an assistant making extension forward, slightly downward and outward, while counter-extension was secured by means of a sheet carried over and down in front of the shoulder and brought back under the arm, traction being made with the two ends of the sheet widely separated, so as not to make pressure upward into the axilla, while I made pressure upon the head of the bone from behind forward toward the glenoid cavity.

Securing the arm to the side, with the forearm in a sling for two or three days, and the use of an evaporating lotion to the shoulder constituted the after treatment. The pain ceased with the reduction, and all the functions and strength of the joint were fully re-established in four weeks.

ACETIZED COTTON.

BY THOMAS W. HARVEY, M.D.,
ORANGE, N. J.

The value of acetic acid as a styptic is often forgotten. In its common form as vinegar, it is familiar to most every general practitioner as a ready means of controlling parenchymatous hemorrhages generally. The nose, gums, and uterus are the situations in which it has been frequently used.

I have recently had prepared by the lint-makers an absorbent cotton, impregnated with acetic acid, of three grades—5 per cent., twelve and one-half per cent., and twenty per cent. Cotton so prepared should be kept moist and be preserved in air-tight bottles. The advantages of the actetized cotton are that, while styptic, it is not corrosive and does not form sloughs; its taste is not unpleasant, and while the 20 per cent. cotton causes smarting when laid upon a denuded surface, yet it is not very irritating, and is antiseptic.

The conditions in which it will be found useful as a styptic are numerous. Some of these conditions are as follows: Epistaxis; hemorrhage from the gums after tooth extraction; in menorrhagia, as a tampon to be placed immediately at or within the os uteri; in cancer of the uterus—indeed in ulcerating cancer wherever located. It is also useful in prolonged flowing from a subinvoluted uterus, or from lacerations of the cervix or vagina after labor. It will control hemorrhage from organs such as the liver, when wounded by the separation of adhesions in

operations in the abdominal cavity—continued pressure for a few moments with the prepared cotton will stop persistent oozing that has resisted hot water and other measures, and which would require otherwise the use of the cautery and result in the formation of a slough.

I have not had sufficient opportunity to determine the relative values of the different cottons, but the stronger will act pretty sharply when there is an abraded surface on the skin. The twenty per cent. cotton may be used about the cervix uteri without pain, and also in many cancerous ulcerations.

The chief advantage of the acetized cotton is that it avoids the disadvantages of the iron styptic cotton now found in the shops.

SOCIETY REPORTS.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, January 23, 1889.

The President, W. W. KEEN, M.D., in the chair.

DR. EUGENE P. BERNARDY read a paper on

Biniodide of Mercury—Its Antiseptic Use.

He first referred to his second paper "On the Value of Biniodide of Mercury as an Antiseptic in Obstetrics," read before the Philadelphia Obstetrical Society (April 1, 1886), and said that he had fully intended leaving the results of his investigations to the medical profession, and letting them, by further trial, confirm the correctness of his conclusions. As regards the solubility of the salt he said that in several papers on antiseptics, the biniodide of mercury is declared insoluble, and therefore difficult to use; in one paper, the cost is the objection, it being stated to be more costly than the mercuric chloride. It is to be sincerely hoped that pecuniary considerations will never interfere in the use of any medicine that will assist in saving a human life. The biniodide is rendered a soluble salt by the addition of iodide of potassium. After mentioning a number of references to the use of the biniodide in current medical literature, he reported several obstetrical cases:

Case I.—Mrs. L., aged nineteen, first pregnancy; was called to attend her (January 24, 1886) in a premature labor; she was pregnant about six and a half months; when I arrived, I found she had been delivered of a dead male child; the placenta came away in two hours; the patient did well up to the evening of January 27th, when she was taken with a chill, which was repeated in three hours; when I saw her on the morning of the 28th, her skin was hot and dry, face flushed, pulse 112, temperature 102°; tongue thickly furred, abdomen slightly swollen and very sensitive; lochia offensive. Ordered quinæ sulphatis, gr. xx.; morphiæ sulphatis, gr. ¼, night and morning; poultice over abdomen, and hot vaginal injections of 1 to 4,000 solution of the biniodide of mercury every four hours; at the second injection the discharges became free from any odor. January 29th, pulse 100; temperature normal. This treatment was kept up, with the exception of the large doses of quinine, to October 5th, when the injections were reduced to one a day for about four days, when the patient was discharged cured.

I have confined this patient since of a full-term, living child; the biniodide injections were used at once; she had a good lying-in; discharged on the ninth day, well. (The above case really belongs to my second series, but the manuscript was mislaid at the time, and found too late to be incorporated in my second paper.)

Case II.—Mrs. M., age thirty-five; fifth confinement; during her pregnancy she had worked very hard, doing almost the work of a man. Was called to attend her in labor, March 18, 1886; when I arrived at her bedside I found she had been in labor since the previous day; she appeared completely worn out, having hardly any strength to bear down; the family refused positively instrumental interference. I gave two doses of the fluid extract of ergot, teaspoonful, repeated in half an hour; under its influence the child was born; the placenta soon followed.

The patient did well up to March 24th, when, in the evening, she had a severe chill, which again occurred the following morning (March 25th). I saw the patient on the following day; she seemed to have aged fully ten years; her face was drawn, and of a deep yellow color, eyes bright and sparkling with delirium; pulse 140, temperature 105°; the abdomen was immensely swollen, and could not bear to be touched, more especially on the right side. Diagnosticated metro-peritonitis. Lochia arrested. Ordered quiniæ sulphatis, gr. xx., night and morning; morphiæ sulphatis, gr. ¼, whenever

pain was severe; hot poultice over the abdomen, hot vaginal injections of 1 to 4,000 solution of biniodide of mercury. March 28th, pulse 120, temperature 101°; lochia returning, abdomen not so sensitive. This treatment was continued up to March 31st; the abdomen now allowed of closer examination; in the right inguinal region could be detected a large mass; vaginal examination showed the uterus bound down and completely surrounded by lymph. Dr. W. Goodell, being called in consultation, verified the diagnosis. The biniodide injections to be continued; internally, quinine sulph., gr. iij., three times a day, besides an alterative tonic. The patient gradually recovered her health, without any additional treatment.

In this case the injections of the biniodide were constantly used for over a space of three weeks, first every four hours, then three times a day, then once a day, without the slightest systemic action of the drug occurring.

Case III.—On July 11, 1886, I was asked to see Mrs. W., in consultation with her family physician; on entering the house a most sickening odor struck my nostrils; it reminded me of uterine cancer in its last stage; the more I advanced, the worse the odor became; at last, I reached the room and bedside of the patient; of all odors, I never want to smell the like again; as the nurse remarked, it was worse than decayed carrion; how the patient lived through such a condition was simply miraculous.

I found she had aborted about two weeks previously, and had declined any interference in regard to extracting the placenta, saying "it will come away." On examination, I found the vagina full of sticky, horribly-smelling, broken-down placental tissue, the mouth of the uterus opened, the uterus full of the same kind of material as found in the vagina; the patient declined the use of any instruments, so I broke down and pulled out all that came within reach of my finger; I then washed out the uterus with a hot 1 to 4000 solution of the biniodide of mercury; not yet satisfied, I washed out the parts with another quart of the solution (1 to 4000), until the water came back clear.

I did not see the patient again, and, in answer to a letter to the attendant physician, I received the following:

"PHILADELPHIA, May 20, 1887.

"MY DEAR DOCTOR: I am glad to inform you that Mrs. W. did very well. The iodide of mercury pellets acted like a charm. There was no unpleasant odor attached to the discharges after we began their employment. . . . I have been an ardent advocate of potassium permanganate, but I am now a convert to the biniodide as an antiseptic."

Case IV.—Mrs. H., primipara, aged thirty, fell in labor November 18, 1886. On my arrival at her bedside, I found she had been in labor for some time, the mouth of the uterus wide open, bag of waters unruptured, vertex presentation. On making abdominal palpation, detected at once a twin pregnancy; after a somewhat lingering labor, the first child (boy) was born; on examination, I found the second child (girl) presenting with vertex left posterior; the head came down very slowly, and, on the solicitations of the patient and family, the labor was terminated with forceps. The patient did well up to the evening of the second day, when, about midnight, she was taken with severe frontal headache and chills. I saw the patient in the chill; half an hour after, her temperature was 104°, pulse 140; delirious; ordered quinine sulphat., gr. xx, at once, and repeat next morning. Next day (November 21), temperature and pulse the same, completely out of her mind; lochia almost ceased flowing, and what was present was offensive; abdomen extremely sensitive to the touch. Ordered the quinine to be continued, gtt. x. tr. digitalis four times a day; hot flaxseed-meal poultices over abdomen, hot injections in the vagina of 1 to 4000 biniodide of mercury every four hours. The following day, the lochia returned normal. The condition of things remained about the same up to November 25, when the symptoms were improved; the patient was discharged well, December 4, 1886.

(The following case was the first patient on whom I used the biniodide of mercury injections, and whose history is given in my first paper, June 4, 1885.)

Case V.—Mrs. D., third confinement (being compelled to leave the city, she fell into the hands of another physician), fell in labor September 6, 1886. After a lingering labor, she was delivered of a still-born child; on the second day, as far as I can learn, all the symptoms of an attack of puerperal fever set in; she remained very sick for several days. No vaginal injections of any kind were used. When I saw the patient, on September 19, 1886, she was suffering with an extremely tender abdomen, more especially on the right side, on which side could be detected a small lump. Vaginal exam-

ination disclosed the uterus partially surrounded by lymph. Discharges from the vagina very offensive. Pulse 100, temperature 101°-102°. Nothing could be retained on the stomach; as a drink, frozen champagne was ordered. Quinine sulphate, gr. x, once a day; equal parts of ungt. hydrarg. and belladonna to be rubbed over the abdomen once a day, followed by hot poultices, hot injections of the 1 to 4000 biniodide three times a day. My following visit found my patient improved, and in a week she was discharged, but it was some time before she regained her usual strength.

On November 1, 1887, I delivered the above patient, after an easy labor, of a large, female child; immediately after the placenta came away, I washed the uterus out with a 1 to 4000 injection of the biniodide; the injections were ordered to be used three times a day throughout the lying-in, which was perfectly normal, and the patient discharged, well and strong, on the ninth day.

Case VI.—Mrs. C., aged nineteen, first pregnancy; was called to attend her on the morning of August 19, 1888. After an easy labor, she was delivered in the afternoon of a large male child; the placenta came away in about twenty minutes. The following day the patient was doing well, but had not been washed, and the odor in the room was very disagreeable. On my following visit I found the patient in a high fever, temperature 103°, pulse 130, full and quick; tongue dry and chippy; the skin from the posterior part of the vulva back to beyond the anus was raw and covered with minute bloody points; abdomen very tender; lochia, what there was, was extremely offensive.

On close inquiry, I found that the mother of the patient, who was supposed to be nurse, had gone on a drunken debauch since the birth of the child, no doubt celebrating her "grandmotherhood"; the patient was placed at once in charge of a competent nurse; hot poultices were ordered to the abdomen; quinine sulph., gr. v, morphia sulph., gr. ¼, every four hours; hot injections in the vagina of 1 to 4000 biniodide of mercury every three or four hours, equal parts of zinc ointment and Goulard's cerate were applied over the raw surface.

August 24th, pulse 110, temperature 101°; lochia coming freely and without odor. August 26th, pulse 100, temperature 99°; 4 P. M., pulse 100, temperature 101°. Condition better, treatment continued; patient discharged, entirely cured, September 1, 1888.

With the three cases reported in my first paper, eight in my second, and the six cases just detailed, in all, seventeen (obstetrical) cases in which the biniodide of mercury had been employed, gives us, certainly, sufficient data to draw positive conclusions.

Abdominal Abscess Intercurrent with Typhoid Fever.—On April 20, 1887, I was requested to see Mary B., aged five years. The little patient had been ailing for the past week, suffering from constant frontal headache; she was very feverish, had lost appetite, and had a diarrhœa. I found her in bed, with a temperature of 103°, very quick, compressible pulse, tongue dry, and a number of rose-colored spots over the abdomen and chest. The case was running the ordinary course of typhoid fever, when, on May 5th, the child was taken with a sudden, sharp pain in the right iliac region; my visit found the child suffering agonizing pain in the abdomen, which was tense and swollen; in the right iliac region could be felt a lump the size of an egg; under appropriate treatment the acute pain somewhat subsided. On May 8th, my attention was called to the navel, which had become red, inflamed, and pouting; on touch, a feeling of fluctuation was imparted to the finger. May 10th, the child passed from the bowels a large quantity of pus; the angry appearance of the navel disappeared, all acute symptoms seemed abated. On my visit of May 12th I found the navel again inflamed, with positive indications of pus underneath; the following day it broke, discharging about a cupful of pus. I now suggested a consultation in regard to the advisability of an operation. It was declined. Same condition continued up to the first of June; the child by this time had become greatly emaciated, constant discharge of pus from the navel, and symptoms of septic poison were commencing to show themselves. At last, on June 12th, consent was given to an operation. June 13th, Drs. Allis, F. Elder, and C. Reed were present. The patient was etherized by Dr. Reed; after a close examination, and taking the weakened condition of the child into consideration, and also that the abscess cavity having made an opening at the navel, it was decided that, instead of opening the abdominal cavity, a counter-opening in the left iliac region be made, and a drainage-tube, extending from the navel to it, be introduced, and the abscess cavity washed out. I washed out the abscess cavity through the tube with a two-quart solution of 1 to 4000 biniodide of mercury; the abdomen was then covered

first with biniodide gauze, over which was laid a layer of the biniodide wool, all held in position by a bandage that had been washed in a 1 to 4000 solution of the biniodide of mercury. The abscess cavity was ordered to be washed out morning and night with a 1 to 8000 solution of the biniodide; the child rallied well from the effects of the ether. While washing out the cavity, on May 17th, a piece of straw came through the drainage-tube. May 22d, discharge of feces through the lower end of the tube, which occurred two days in succession; for the following ten days, when the child partook of food, more especially if this was an egg, within a half hour some of it partially digested would appear at the end of the upper part of the tube; if the discharge occurred later than a half hour, it would appear at the lower end of the tube: this clearly demonstrated a fecal fistula in connection with the abscess cavity. Gradually all discharges ceased, and the tube was taken out, July 23, 1887; a week later both openings were closed, but it was several months before the child could resume her ordinary diet; apples would invariably bring on severe colic.

None of us at the time of the operation went further than to "hope" that the little patient would get well. The case demonstrates well the antiseptic properties of the biniodide. It was an extremely warm month, and, with the exception of the two or three days on which the feces passed down through the tube, the odor of the discharges was held in abeyance.

Double Laceration of the Cervix.—Mrs. F. had a large, double laceration of the cervix following a natural labor. I first saw the case in May, 1885, and advised operation. Operated October 5, 1885. Extensive denudation had to be made; fourteen silver stitches were necessary; hot water was used to cleanse the parts during the operation. On the second day a very offensive bloody discharge occurred. The vagina was washed out with a hot 1 to 4000 solution of the biniodide of mercury three times a day; at the first injection all odor disappeared, and did not return throughout the rest of the treatment; the stitches were taken out on the tenth day, with perfect union.

Abscess of Right Foot.—In February, 1887, I was called to see Master McG. About a week previous a heavy box fell on his foot; painful at the time, but not painful enough for him to give up his work, he continued to work up to February 10, 1887; on the previous evening his foot became swollen and painful; under poultices the inflammation centred, and on February 20th the abscess broke. The opening was stubborn to heal; offensive pus was discharged; every day I injected the cavity with a 1 to 2000 solution of the bichloride of mercury and packed; this treatment was kept up for ten days without any change; the bichloride was then changed to a 1 to 4000 solution of the biniodide of mercury, the discharges were made pure, and in the course of another ten days the opening closed, but the foot remained tender for several weeks.

Abscess Extending from the Right Axilla.—W. S., aged thirty, barber, of scrofulous habit, somewhat dissipated, having a wart on the right middle finger, picked it with his finger-nails; the result was an acute inflammation of the entire arm. I saw the case July 16, 1888; under cooling applications, the inflammation soon abated. About July 21, 1888, the right side, extending from the axilla down to midway between the last rib and the crest of the ilium became intensely inflamed; the pain was excruciating, and large doses of sulphate of morphia gave only momentary relief; large flaxseed poultices liberally sprinkled with laudanum were applied. On the 24th I detected fluctuation at the lower border, made an exploratory incision, and obtained half a cupful of fetid pus and broken down blood; this gave slight relief. On the 26th the pain returned tenfold; the same evening, the patient having been etherized by Dr. S. Solis-Cohen, I enlarged the previously made incision to three inches, and about half a pint of extremely fetid pus was discharged; the finger was then introduced, and two encysted pus sacs, situated at the edge of the scapula, were ruptured, and another half pint of pus was discharged; the cavity was then washed out with a 1 to 4000 solution of the biniodide of mercury, a drainage tube introduced, flaxseed poultice applied, and over all a layer of biniodide wool.

Next day I found the patient had had a good night's rest; I removed the poultice; cavity to be washed out three times a day with the biniodide; drainage tube taken out on the fourth day, and within a week the patient was discharged well. It is hardly necessary to state that good nourishment, iron, and quinine were ordered. After using the biniodide no odor was perceptible in the discharges.

Three Cases of Carbuncle.—April 25, 1887, I was asked to see Mrs. P., aged seventy-two, and found her suffering with a carbuncle on the back of the neck, six inches long and four inches wide. It was

riddled with a number of suppurating points; on the previous day the patient had been given up by her medical attendant as incurable. On Sunday, April 24, 1887, after the patient had been etherized, the wound, instruments, and sponges were made antiseptic by being washed with a 1 to 4000 solution of the biniodide, after which a crucial incision was made and all the hardened tissue dissected out, down to healthy tissue, thoroughly washed out with the biniodide, and a flaxseed meal and charcoal poultice applied; the sore to be well washed three times a day with the biniodide, when a fresh poultice was applied. Internal treatment, iron, quinine, and full diet. In twenty days the patient was discharged well. The disagreeable odor in this case was not entirely dissipated, but was held under control.

Case II.—Mr. B., coal merchant, aged forty. Carbuncle in right shoulder, size of an egg, hard, indurated, extremely painful to the touch, and a point of suppuration at the centre; the case was seen April 7, 1888. The next day, after the patient had been etherized, I made a deep crucial incision, and dissected out all the hard indurated tissue; the same treatment was used as in Case I. No odor connected with the discharges. Patient discharged, cured, in two weeks.

On October 20, 1888, I was again asked to see the above patient. I found him suffering from an attack of herpes of the back of the neck, which was, in a few days, followed by a number of abscesses, two of them resembling small carbuncles. A charcoal poultice was applied, and in three days all the abscesses were opened, but during the following week there seemed to be no change for the better. I then ordered a piece of linen to be saturated with a 1 to 4000 solution of the biniodide and applied to the surface, and over this a flaxseed-charcoal poultice; within forty-eight hours, the angry appearance of the abscesses and skin abated, and in four to five days more, all inflammation had disappeared, when the patient was discharged.

Case III.—J. E., aged sixty-nine, was taken sick about three weeks previous to my seeing him. It first commenced with a painful tumor on the neck. When I saw the patient (July 19, 1888), the entire surface from the superior curved line of the occipital bone down to the seventh cervical vertebra and from ear to ear was one immense suppurating surface, covered with a thick yellowish green membrane. The discharges were highly offensive. Pulse quick and compressible; slightly delirious; tongue covered with a thick, black, highly offensive membrane. Ordered a piece of linen to be saturated with a 1 to 4000 solution of the biniodide and applied over the surface, and over this a charcoal-flaxseed poultice every three hours. The odor was held in abeyance. This treatment was continued for about ten days, when the surface became clear of all adventitious membrane. Poultice was continued; carbolic acid was ordered in place of the biniodide. Patient discharged, cured, September 20, 1888.

Dr. S. Solis-Cohen saw the case for me in August, and we concurred in one prognosis, which was death; but we were more than agreeably surprised.

Biniodide of Mercury Wool as an Application over the Chest in Pulmonary Troubles.—When, in the winter of 1886, I first ordered the chest of a child suffering with catarrhal pneumonia to be enveloped in a layer of the biniodide of mercury wool, it was simply to overcome the disagreeable matting of the cotton. The child, previously to its use was very restless, and seemed to suffer pain. On the following visit I found that the little patient had had its first quiet sleep since the commencement of its sickness; since then I have almost entirely discarded the use of cotton. The results in a number of cases lead me to believe that there must be something more than the warmth of the wool. Can it be that the heat of the body disengages the biniodide, and as the consequent result, the patient is constantly surrounded by an antiseptic atmosphere?

In a case operated on for cancerous constriction of the bowel, by Dr. Charles B. Penrose, the patient, about the fourth week, was seized with a sharp pain in the right side below the nipple; counter-irritants did not relieve her; on auscultation, crepitant rales were easily detected in the lower right portion of the lung, under the point where the pain was complained of; the side was enveloped in the biniodide wool, and within twelve hours the pain had entirely disappeared. In the neuralgic pains always present in a case of phthisis, I have found the wool invariably to diminish, if not entirely dissipate the pains, and the expectoration seems easier and in smaller quantities.

My attention was called to the following by my office-pupil, J. N. England: "Biniodide of Mercury Pulverization for Tuberculosis" (*American Journal of Pharmacy*, October, 1888). Miquel and Rueff's for-

mula is given by the *Arch. de Phar.*, September 5, 1888, as follows: Biniodide of mercury and iodide of potassium, of each 1 gramme; distilled water, 1000 grammes. The solution is stable. At the beginning 10 c.cm. are sprayed once daily; to be increased to 25 c.cm. twice daily. The larger portion of the liquid should be inspired. It reaches the lungs, says the author, but salivation does not follow, even after months of treatment. The sputa changes in character and diminishes in quantity; the number of microbes is lessened, but these organisms rarely disappear completely. The cough increases at first, and afterward subsides.

If my theory of the disengagement, by heat, of the biniodide from the wool be correct, its action will readily be explained by the above experiments of Miquel and Rueff.

Disinfectant of Typhoid Fever Stools.—For the past two years I have used the pellets of the biniodide dissolved in the alvine discharges of typhoid fever, and the results have always been satisfactory.

In the spring of 1886 I treated an extremely bad case of typhoid fever; the patient was broken down from dissipation, having had, about two weeks prior to his illness, an attack of delirium tremens; the alvine discharges numbered from twenty to thirty a day, and were highly offensive; chloride of lime, and different forms of chloride and sulphate of iron were used without any diminution of the sickening odor. I then ordered two (1 to 4000) pellets of the biniodide of mercury to be dissolved in a half pint of water and placed in the bed-pan, to be renewed every time the pan had been used by the patient; the odor was completely dissipated, and kept so.

In another case the bichloride of mercury pellets were used without success; the biniodide pellets gave the desired result. In a case of labor which, at the end of the lying-in, terminated in an attack of typhoid fever, the nurse used the biniodide pellets on her own account in the bed-pan, there was no disagreeable odor throughout the course of the disease.

The description of the action of new medicinal preparations or new properties to an old medicine necessitates tedious histories of cases; this must be my excuse for dragging through such dry details.

It is not my intention to present to you the biniodide of mercury as the one and only infallible antiseptic; I simply present my results, and have tried to give impartial histories, without exaggeration, simply as they have occurred. But the action and results of the biniodide of mercury fully strengthen my belief in its stronger antiseptic value and non-irritating properties over the bichloride.

After some remarks by Dr. Woodbury, Dr. Bernardy closed the discussion. He said: From the start I objected to the shape of the pellets, thinking that they looked too much like candy, and I think that there will soon be a change, so that this danger will be avoided. The pellets of bichloride look very much like chlorate of potassium lozenges, with the exception that the word "poison" is stamped on them.

In regard to this being a double salt. This was the first thing that struck my attention. When I first used this preparation, in 1884, I dissolved the biniodide in alcohol. This was found to be inconvenient, and through the kindness of Mr. Hayes, who allowed me the use of his laboratory, his assistant and I worked up this subject. We added iodide of potassium, and then found that the slightest moisture imparted to one pellet was enough to destroy the entire bottleful. We then decided to add the muriate of ammonium, which prevents this chemical reaction until the pellet is thrown into water. The pellet goes in as the biniodide of mercury, and the iodide dissolves it, but before the change takes place it has been used upon the patient.

In regard to my use of this preparation. I have studied it faithfully, and have tried to look upon the cases in an unbiassed way, and to give a fair history of them. I have sometimes first used the bichloride, and it has not fulfilled the indications as the biniodide has done.

—The *Medical Press and Circular*, Feb. 6, states that an action was recently brought against M. Poncet, Surgeon to the Val de Grâce Military Hospital, for $10,000 damages for having performed the operation of breaking down the adhesions in an anchylosed knee, the result of which did not fulfil the expectations of the patient. The Tribunal declined to enter into the technical question of the propriety of the operation, and restricted their consideration to proofs of negligence or manifest incapacity. A verdict was arrived at exonerating the defendant on the ground that although unsuccessful, the operation had been performed after due deliberation and with every necessary attention.

REPORTS OF CLINICS.

BELLEVUE HOSPITAL, NEW YORK.

MEDICAL CLINIC—PROF. A. A. SMITH.

Broncho-Pneumonia.

Prof. Smith presented a patient to illustrate an important fact which he had just previously laid stress upon in his lectures; namely, the great significance of the combination of the three physical signs—broncho-vesicular breathing, increased vocal resonance, and slight dulness. The patient, a man 36 years old, had been an inmate of the Hospital for many years, on and off, and always had a simple bronchitis. Dr. Smith himself had examined him many times before. A short time ago he was again admitted with the same trouble, the physical examination of his chest showing nothing but a general bronchitis. Three days ago, however, he suddenly had a chill, his temperature went up to 105° F., and his cough and dyspnœa increased. He complained of no pain. His fever continued, controlled to some extent with five-grain doses of antifebrin, and to-day is 102° F. The examination of his urine is negative.

The question arises, is his present condition the result of his bronchitis alone, or of something else? Physical examination of his lungs shows the presence of dry and moist rales all over, and posteriorly at the right apex a very localized spot presenting dulness, broncho-vesicular breathing, and increased vocal fremitus. This small area of consolidation did not exist before the occurrence of the chill three days ago, and it is so limited in extent that the most careful examination is necessary to determine it. It is a broncho-pneumonia; and what is its significance? There is no heart disease, and examination of the abdomen is negative. It is probable, therefore, that the inflammation is tubercular. The sputum has not yet been searched for the tubercle bacillus: but even if it is not found the diagnosis is not rendered clearer. A good prognostic sign and one against a tubercular process is the non-involvement of the pleura. And it is not altogether unlikely that the pneumonia may clear up and the patient recover. But if this does not occur in two weeks time we may quite positively diagnosticate phthisis.

These cases often occur in practice and are sometimes not so clearly defined as this one. With the bronchitis there may be no increase of cough or fever, and only the most careful examination will reveal the presence of consolidation. Moreover, the physical signs of this condition may not be very pronounced.

Lobar Pneumonia; Pericarditis.

The second patient was a man, 25 years old. Six days ago he was attacked with chill, fever, pain in the left side, cough, etc., and on admission to the Hospital he presented all the signs of lobar pneumonia. During the night he had mild, muttering delirium. After three days, his delirium suddenly became violent; he jumped from bed and rushed to the window and would have thrown himself out if he had not been promptly restrained and by force carried back to his bed. His temperature increased, and cyanosis developed. With this history pericarditis was at once suspected to have developed, and examination revealed a marked pericardial friction sound, which had not previously existed.

This sudden delirium in pneumonia very often signifies the access of pericarditis. To be sure the delirium may be due to other causes, as alcoholism or renal disease, or occur independent of any complication; but the frequency of its connection with pericarditis is more than a coincidence.

The patient has been taking half an ounce of brandy every half hour, day and night. His delirium is much improved and his cyanosis diminished. His pulse is now 140, compressible, but not very feeble. The rules laid down in a previous lecture relative to the use of alcohol are: consideration whether the illness be of long or short duration; the presence of a dry brown tongue; a feeble pulse of 120 or over, and increased first sound of the heart; and cyanosis. In this case we cannot be guided by the pulse altogether, and by the heart not at all. We notice the tongue to be dry and brown and fissured (what is called semi-typhoid), and we have the cyanosis—sufficient indications for stimulants. It is now the sixth day of the disease, and in twenty-four hours there will be, probably, a fall of temperature, for Dr. Smith believes the prognosis to be good.

In these cases of pneumonia the diagnosis is easy. There is almost always a chill (in 59 cases recently observed there was no chill in 14); and it is usually well marked, as in this case, lasting one-half hour. The pain in the side, the cough and finally the

physical signs, are usually prominent and characteristic.

With reference to treatment: if there be much cough, dyspnœa or nervous symptoms, give opium and control the nerves. If complications arise, give more opium and add alcohol. Dr. Smith believes opium the most valuable drug in pneumonia. It does not treat the pneumonia, but the patient. Give sufficient to relieve the pain and just moisten the skin. It certainly renders the patient comfortable.

Phthisis.

The third patient was a woman, 37 years old, the mother of eleven children. Six years ago the patient had pneumonia of the right lung, and at that time was in bed six weeks. She has had no sickness since. For some weeks previous to three weeks ago she had had slight cough but no fever and no physical signs of consolidation of the lung, so we are told. Three weeks ago she began to expectorate blood and complain of moderate pain in the right side, high up.

To-day, physical examination shows, at the right apex, retraction and diminished movement, dulness, to three or four inches below the clavicle, bronchial breathing, and rude voice. The patient has laryngitis, and her voice and vocal fremitus are not therefore reliable. The patient has had several slight hæmoptyses since the first attack; sometimes the blood is bright and frothy, sometimes it is dark and clotted. It is probable that this condition of the lungs has existed longer than three weeks.

Hæmoptysis does not make the prognosis in this case more favorable or more unfavorable. The late Dr. Flint has said that life is longer in those patients who had this symptom.

Dr. Smith would prefer, were he the subject of phthisis, to have a moderate hæmoptysis occasionally, and would then consider his chances better; for this symptom seems to occur in the long-continued cases. There are to-day, among many such examples, several practising physicians in New York, old men, who had hæmoptysis thirty and forty years ago.

The treatment in this case should be toward improving the general health. Astringents do no good.

Typhoid Fever.

The fourth patient was a man 20 years old, a machinist. He had been nine months in the United States. He is not intemperate. He was well up to five days ago; he then complained of chilly sensations, cough, headache, and feeling "light and dizzy." There has been no nose-bleed and no pain. The bowels move once a day; are free, but not watery, and are of natural appearance.

The temperature is 103°; pulse, 110. The patient is pale and dull of apprehension. There are slight diffuse bronchitis; enlarged and tender spleen and liver; gurgling and tenderness in both illiac fossæ.

The diagnosis rests between malarial and typhoid fevers, and quinine, in sufficient doses, should be administered to settle this point. If after three days, the temperature is not controlled, the case is probably one of typhoid fever.

New York Correspondence.

Treatment of Club-foot at the University Medical College.—A good caustic for Cancer.—Clinics of Drs. Bull, Thomson, and Winters.

New York, Feb. 16, 1889.

Two years ago Dr. N. M. Schaffer was succeeded as lecturer in orthopædic surgery in the University Medical College by Dr. A. M. Phelps. A more radical change would be hard to conceive. Prof. Schaffer is a disciple of braces and similar instrumental appliances, rather than of the knife; while Prof. Phelps is directly the opposite. The latter has now operated on nearly one hundred cases of club-foot without a failure and without a death, his highest temperature being 103°. He says he has never seen the case that operation will not cure. His good results are explained by his perfect knowledge of the subject, his skill and fearlessness in operating, and by the strictness of his antisepsis. He lays down the following rules of treatment: If a foot can be reduced by a reasonable amount of force in a reasonable time, do not operate; if not, the foot should be treated first by subcutaneous tenotomy; if this fails make a large open incision and cut everything; should this fail because of deformity of the bone, perform linear osteotomy of the neck of the astragulus; if the deformity is still unreducible, cut out a V shaped piece of bone; and lastly, if it remains then unreducible, cut off the foot. He considers it better to have a shoe stuffed with cotton and going naturally forward than one filled with a deformed foot and going backward like a crab. Prof. Phelps is also lecturer on orthopædic surgery in the Postgraduate School.

In cancers unamenable to treatment by the knife, Prof. Stephen Smith uses the following caustic: Heat sulphate of zinc till the water of crystalization is driven off and the sulphate falls into a powder. Add pure sulphuric acid to any desired consistency, that of mortar being preferable. This paste when applied produces a granulating surface that heals with surprising rapidity.

At the clinic of Prof. W. T. Bull, in New York Hospital recently, ovariotomy was performed for pyosalpinx. The tubes and ovaries were found bound down behind the uterus. They were torn loose without rupture and without great bleeding, and then, after the usual ligatures had been applied, they were removed. The Doctor feared hemorrhage and left in the wound a large glass tube, to which the nurse was instructed to apply suction with a syringe at intervals. Bleeding would thus be detected and free drainage at the same time obtained. He next operated on a case of ventral hernia. The patient was forty years of age and a janitress by occupation, compelled to do a great deal of walking up and down stairs. The hernia when tense was as large as a hen's egg, and gave considerable pain. Though the hernia was of long standing, no truss had ever been worn for it. It was easily reduced. Dr. Bull said he had not had a large experience in this variety of hernia but he believed that the results of operation were not brilliant, especially when the walls of the abdomen were weak and flabby. In this case they were strong and muscular and by excision of the sac and careful approximation of the edges of the muscle he hoped for a good result. A number of large vessels were found in the sac, but no serious trouble resulted.

At the clinic of Prof. W. H. Thomson, a policeman presented himself who apparently was the picture of health. His pulse, however, was irregular. He complained of headache and disordered secretions, sometimes diarrhœa at other times constipation. His worst symptom, however, and the one for which he came for relief, was insomnia. He could find nothing that helped him. Dr. Thomson said it was due to disordered circulation and fermentation in the intestine. He ordered:

℞ Tr. strophanthi . . . . . gtt iv
Spir. ammoniæ aromat. . . . . f℥j

M. Sig. Take on retiring. To be repeated in four hours if the first dose does not put him to sleep.

After two weeks ten to fifteen grains of chloral hydrate with gentian, whiskey and iron may be substituted. If strophanthus fails to regulate the heart, digitalis may be tried. For the intestinal fermentation salicylate of soda and salol were given. The Doctor said insomnia may be the result of habit, in which case it should be treated with chloral hydrate until the habit is broken. Another cause is worry or mental strain. This variety is most dangerous and may lead to epilepsy or insanity. In this case give:

℞ Dilute hydrocyanic acid . . . gtt xvj
Majendies sol. morphine . . . f℥j
Chloral . . . . . ℥ jss
Syrup of ginger . . . . . f℥j
Camphor water . . . . . ad f℥vj

M. Sig. Dose, for ordinary case, tablespoonful; for severe case, two tablespoonfuls.

This prescription is also good for the sleeplessness of fatigue.

Prof. J. E. Winters, in a course of clinics and lectures on diphtheria in children, at the University Medical College, has laid down the following rules for its treatment. It is the treatment followed in his private practice and in the University and De Milt Dispensaries, and he vouches for its results. Exhaustion and laryngeal complications are the chief causes of death, and are the things to combat. To prevent the former put the patient in bed and keep him there, no matter how mild the case may be. The latter cause of death is always brought on by exposure, and hence the bed should be placed out of reach of all draughts and the patient's neck should be kept warm. If flaxseed poultices are used they must be kept hot and changed every hour at least. A good method is to apply fat pork or bacon well sprinkled with pepper, both to the neck and up the sides of the face. Use heat by the inhalation of steam. As it is exhausting do not use it constantly but for ten or fifteen minutes, several times daily. Sulphurous acid, obtained easily by burning a piece of sulphur in the room, aids in the exfoliation of the membrane, reduces congestion and promotes the health of the sore. Local treatment: When the diphtheritic inflammation is under direct observation, as on the tonsils, local treatment is of little avail, and, as it causes struggling and consequent exhaustion, is contraindicated. In nasal diphtheria, however, the local treatment is most important and can be had without exhaustion. Place the patient on the edge of the bed and use a Davidson syringe until a passage is obtained through the nostrils. The saturated solution of

boracic acid is the best application and, if there is putrefaction, alcohol can be added (f ʒ ss to Oj). General treatment: Begin with calomel (gr. ij into ten powders, one every hour) as it stimulates all the secretions. Iron in full doses is indicated. Ten drops of the tincture of the chloride can be given and, if borne, doubled after twenty-four hours. If there is sepsis even (fʒj) doses can be given. If quinine does not irritate, it should be given in tonic doses (to a child two or three years old, gr. j t. i. d.). Give alcohol only when the pulse indicates its necessity, beginning with gtt. x. If the disease is extending downward, in addition to the above burn tar in the room. Its *modus operandi* is unknown, but it relieves the symptoms and also spoils all clothing with which it comes in contact. Carry the nutrition of the patient to the highest pitch with milk and beef tea.

PERISCOPE.

On Gas-Cysts of the Vagina.

Professor Obrzut (pronounced "Objüt"—a Polish name), of Prag, Bohemia, says (*Wiadomosci Lekarskie*, Aug., No. 2, 1888) that Dr. Jacobs, of Bruxelles, working under his guidance, has succeeded in elucidating the pathogenesis of a rare and curious affection of the vagina. This consists in the development of multiple small-sized cysts with gaseous contents, described by Professors Chiari and Breisky under the name of "emphysematous vaginitis." While both of the authors just named, as well as Dr. Piering, believe that the disease represents primarily a lesion of the vaginal lymphatic apparatus, Drs. Obrzut's and Jacobs's researches have shown that the cysts originate solely in the vaginal blood-vessels, the lymphatics remaining wholly intact. According to the latter authors, the first stage of the pathological process seems to consist in œdematous swelling affecting fairly circumscribed isolated areas over the vascular wall; the second stage is a progressive, correspondingly limited or localized obliteration of the vascular lumen; while a third stage consists in a more or less considerable gradual dilatation of the vessel above its stenosed portion. Those dilated departments of the vascular tube in the course of time are transformed into cystiform structures, while their bloody contents undergo disintegration which, amongst other products, yields odorless and colorless gases. As to the microbes described by Eisenholz, they could not be discovered in the cysts by any method of examination.

Friedreich's Disease.

At the meeting of the Medical Society of London, Jan. 28, Dr. Harrington Sainsbury brought forward two cases of Friedreich's disease. The first occurred in a compositor, twenty-three years old, single, who was treated at the age of fourteen for St. Vitus' dance. The ataxia, the patient says, developed a year or two later. He had an attack of abdominal symptoms of obstructive character at the age of nineteen, and since then the ataxia had increased. The incöordination presented the characters usual in locomotor ataxia, affecting the arms and legs, but being most marked in the latter. There appeared to be some muscular weakness, the head was occasionally unsteady, the speech was thick, and the eyes showed slight lateral movements when looking upward. The pupils were equal, contracting to light and accommodation; the discs were normal. Sensations as of "pins and needles" were felt occasionally in the hands and feet, and cramps sometimes in the legs; the patient felt the ground under him. On testing the sensation, it was found slightly dulled in the feet and legs; there was no delay in perception. Muscular sense for posture and estimation of weight was fairly precise; the superficial reflexes and knee-jerks were absent, and there had been no urinary trouble. The facial expression was blank.

The second patient was a brother of the first, two years younger, presenting a similar condition, but the thickness of speech and blankness of expression were more marked. There was a third brother in the family affected in a like manner. The lesion was identical in position with that of tabes, but there was absence of pain and of cramps.

Dr. Ormerod quoted several cases which had at first, and often for considerable periods, been mistaken for St. Vitus' dance. Looking at the constant unsteady movement in these cases, it was very hard to say that chorea was altogether absent. Dr. Sainsbury's case became worse after an acute abdominal attack; he had noticed a similar tendency to development of the affection after acute diseases—*e. g.*, scarlet and typhoid fevers.

Dr. Sainsbury, replying to a question from Dr. Beevor, said that the father was a drunkard, but there was no family history of neurosis.—*Lancet*, Feb. 2, 1889.

Bacteriology and Antisepsis of the Conjunctival Sac.

In the St. Petersburg weekly *Vratch*, Nos. 43 and 45, 1888, p. 879, Dr. Joseph S. Felser, of Kazan, describes his instructive bacterioscopical researches, undertaken for the purpose of studying mycotic life within the human conjunctival sac, as well as with the view to discover the best method of aseptic and antiseptic management of the conjunctiva in cases of ophthalmic disease and operations. The main outcome may be condensed thus: 1. The conjunctival sac in man always, both in health and disease, contains large numbers of microbes of different species. 2. This mycotic "store" is incessantly kept supplemented and refreshed by a free supply from enormous masses of microörganisms invariably present in the surrounding air. 3. The numerical strength of the conjunctival microbes is directly proportionate to that of the air bacteria. 4. Of pathogenic microbes, the predominating species are the *staphylococcus albus*, *citreus*, *aureus*, and *diplococcus*, the first two forms prevailing also under absolutely healthy conditions. 5. In conjunctival catarrh, the *staphylococcus pyogenes aureus* occurs most constantly and in greatest numbers. 6. In inflammation of the lachrymal sac the diplococcus is invariably present, and that usually in a "pure culture." 7. Panophthalmitis developing after extractions of cataract is caused by the *staphylococcus pyogenes aureus* present in the conjunctival sac. 8. Of antiseptic ophthalmic means in vogue, corrosive sublimate (in the form of irrigations with a solution of 1 to 6,000) is exceedingly weak and untrustworthy in its action, while boracic acid (in the form of irrigations with a three per cent. solution) and iodoform (in powder) are ineffective altogether—they are powerless to destroy the vitality of the microbes or even to arrest their proliferation. 9. The best aseptic and antiseptic means yet known for use in eye practice, is, undoubtedly, trichloride of iodine (ICl_3) recently introduced into surgical practice by Drs. O. Riedel and C. Langenbuch. 10. While being wholly innocuous and void of any irritant properties, the trichloride is most effective in the destruction of microörganisms of any species. 11. In suppurative affections of the conjunctiva, the irrigation with a weak solution (1 to 6,000), repeated three, four, or five times a day, never fails to bring about rapid and striking amelioration. Even after the first three or four sittings, the purulent discharge becomes trifling or often ceases altogether, congestion lessens, and all unpleasant subjective sensations disappear without leaving any trace.

A New Deodorant.

Bromine has for a long time been recognized as being valuable in the treatment of gangrene and foul-smelling ulcers, but until recently its merits as an effectual and cheap deodorant have not been appreciated: It was brought into prominence a few months ago by Mr. Martin, the chemist of the Health Department of New York City, who suggested its use upon the earth thrown up in laying the electric subways. As it is a by-product obtained in the manufacture of salt and is not used extensively in the arts, it is sold at a very reasonable price—about seventy cents per pound. It has the property of precipitating the hydrocarbons of illuminating gas, and thus can be used to deodorize the earth exposed in excavations in the vicinity of gas-mains. More valuable than this is its effect upon decomposing organic bodies, which it renders completely inoffensive. This property renders it especially valuable for use in stables, privy-vaults, urinals, cess-pools, or in any place which may contain foul-smelling organic matters. It is soluble in about thirty-three parts of water, but a solution of this strength is not advisable, as there is a constant escape from it of the vapor of bromine, which is very irritating to the eyes and air-passages, and which may even attack wood and metals. For ordinary purposes it is used in solutions containing one part by weight to about eight hundred of water. In this strength it may be used freely without its affecting anything which it may touch. A few gallons used daily will remove all ammoniacal odors from stables, or a few quarts will thoroughly deodorize the entire plumbing system of an ordinary house. It also might be used with advantage upon ordinary house garbage, which usually becomes offensive so speedily in warm weather. There would appear to be scarcely any limit to its usefulness in this branch of sanitary science, and it will, as soon as its merits are better known, undoubtedly be adopted universally as a substitute for the deodorants now in use, which usually act by substituting one unpleasant odor for another. The only drawback in its use lies in the fact that the undiluted bromine is strongly corrosive, and, if it touches the skin, causes a painful burn. Where it is used in large quantities

this can be obviated by opening the bottle or, what is simpler, breaking it under water. As its use becomes more extended it will undoubtedly be put up in pearls or tubes containing only as much as would be needed at one time in the average household.—*N. Y. Med. Journal*, Feb. 2, 1889.

Compound Gonorrhœal Infection.

Bumm, in prosecuting his studies upon the gonococcus, has discovered that infection by two distinct varieties of micro-organisms can take place, the first preparing the way for the entry and development of the second.

Thus pyogenic microbes may enter one of Cowper's glands after the gonococcus has destroyed its glandular tissue and caused cystic degeneration, and produce suppuration. The mucous membrane of the bladder or urethral follicles may be affected by the staphylococcus in like manner, and the pelvic connective tissue may be invaded. Tubercular disease of the epididymis and tuberculosis of the Fallopian tubes have been known to follow closely upon a gonorrhœa, and are explained in the same way. In gonorrhœal rheumatism the micrococci found in the fluid of the joints are pyogenic, but why they should make their way to the articulations, and the gonococci not do so, is a question still unexplained.

Another source of error is the nodular lymphangitis of blennorrhagia. Small olive-formed tumors are produced along the course of the lymphatics as large as a cherry-stone or a small nut, and are firm, hard, and resistant. They arise insidiously upon the prepuce, but their seat of predilection is the glando-preputial groove, and when hidden by a phimosis they are especially liable to cause an erroneous diagnosis. The diagnosis can, however, be made with almost certainty by the adenopathy, when multiple indolent and long-lasting ganglionic enlargements are present.

These lymphatic nodules are essentially prone to resolution, but when they ulcerate, as they sometimes do, typical indurations characteristic of chancre are presented. Here the only element of diagnosis is found in the evolution of the disease. The indurated chancre never begins as a nodular lesion which opens like an abscess. The diagnosis of chancre should never be made from the objective signs alone. The ecthyma of scabies may easily lead into error, resembling, when covered with a crust, the *chancre crofiteux;* or when excoriated, red, and ulcerating, the ordinary chancre. The glands are often implicated in scabies, and the error of overlooking a chancre in a patient with lesions of scabies upon the genitals must be borne in mind. Treatment directed against the itch will soon make the diagnosis clear.—*Journal of Cutaneous and Genito-Urinary Diseases*, Feb., 1889.

Absorption of the Tissues of the Mouth from Pressure.

The absorption which occasionally takes place from constant pressure upon the tissues of the mouth was well exemplified by two cases brought forward at the Odontological Society of London recently by Mr. Hern and Mr. E. Lloyd Williams respectively. In the first case, the patient had been wearing a set of artificial teeth, the upper and lower of which were attached by means of springs. She had not removed these teeth from her mouth for several years, and, as a result, the lower had become buried in the floor of the mouth; it was also so twisted round as nearly to sever the anterior pillar of the fauces. There was found to be complete anæsthesia of the right half of the tongue and corresponding portion of the floor of the mouth, also complete loss of the sense of taste on that side. There was no pressure on the inferior dental nerve, as sensibility was present in the skin over the chin. The plate was removed with considerable difficulty, and caused much hemorrhage. Some weeks later Mr. Hern observed a whitish cord passing across the gap in the anterior pillar of the fauces; this proved to be the gustatory nerve, and on pinching it with tweezers a tingling sensation was felt in the tip of the tongue. Nine months later sensation had partly returned in the tongue.

Mr. Lloyd Williams showed a man who had extracted two loose molars for himself, the sockets of which probably communicated with the antrum. The patient, being annoyed by the cavity, plugged it with gutta percha, gradually increasing the size until a plug was used measuring more than an inch in diameter. The hole, however, was much larger than this, as the patient was in the habit of encircling the gutta percha with a piece of lettuce leaf. The walls of the antrum presented in places foul ulcerated spots, which, however, speedily disappeared when an obturator was placed in the mouth and antiseptic injections were used.—*Lancet*, Jan. 19, 1889.

THE

MEDICAL AND SURGICAL REPORTER.

ISSUED EVERY SATURDAY.

CHARLES W. DULLES, M.D.,
EDITOR AND PUBLISHER.

The Terms of Subscription to the serial publications of this office are as follows, payable in advance:

Med. and Surg. Reporter (weekly), a year,	**$5.00**
Quarterly Compendium of Med. Science, -	**2.50**
Reporter and Compendium, - - - -	**6.00**
Physician's Daily Pocket Record, - -	**1.00**
Reporter and Pocket Record, - - - -	**6.00**
Reporter, Compendium, and Pocket Record,	**7.00**

All checks and postal orders should be drawn to order of

CHARLES W. DULLES,
N. E. Cor. 13th and Walnut Streets,
P. O. Box 843. Philadelphia, Pa.

☞ SUGGESTIONS TO SUBSCRIBERS:

See that your address-label gives the date to which your subscription is paid.
In requesting a change of address, give the old address as well as the new one.
If your REPORTER does not reach you promptly and regularly, notify the publisher *at once*, so that the cause may be discovered and corrected.

☞ SUGGESTIONS TO CONTRIBUTORS AND CORRESPONDENTS:

Write in ink.
Write on one side of paper only.
Write on paper of the size usually used for letters.
Make as few paragraphs as possible. Punctuate carefully. Do not abbreviate, or omit words like "the," and "a," or "an."
Make communications as short as possible.
NEVER ROLL A MANUSCRIPT! Try to get an envelope or wrapper which will fit it.
When it is desired to call our attention to something in a newspaper, mark the passage boldly with a colored pencil, and write on the wrapper "Marked copy." Unless this is done, newspapers are not looked at.
The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterise communications intended for publication.

EXTIRPATION OF TUMORS OF THE BLADDER.

The general adoption of the operation of supra-pubic cystotomy in Europe has led to much more frequent attempts to remove tumors of the bladder than were made a few years ago, when only the difficult and uncertain route through the perineum was open to surgeons. At present no tumor is permitted to make serious advances or to do serious harm to a patient under the observation of a surgeon without an effort to remove it; and nowhere is this more true than in Paris, where the supra-pubic operation is practised almost to the exclusion of other methods.

An illustration of the scope of this operation is furnished by a case described in a recent lecture by Dr. Bazy, at the Hôpital Beaujon, which is reported in the *Bulletin Médical*, January 16, 1889. In this case, after the usual history of a papilloma of the bladder, the patient came under the care of Dr. Bazy, who opened the bladder from above the pubes, and removed a tumor about two and one-half inches in diameter, situated on the right side of the bladder and encroaching a little upon the *bas-fond*. After describing the operation—in which he unwittingly cut off the lower end of the right ureter—Dr. Bazy states his opinion that excision of tumor of the bladder is preferable to enucleation, or scraping, or cauterization. Total ablation is, he thinks, the only way of dealing with these new growths, and that this should be practised as early as possible and made as thorough as possible. The line of excision, he says, should pass through the healthy mucous membrane, and it may even include the opening of one or both ureters, if necessary. In case this is necessary, he thinks the stump of the ureter should be attached to an opening in the bladder-wall, made to receive it. Of course, in such an operation the wound in the bladder and abdominal wall should not be entirely closed, and a suitable drainage-tube should be left in the bladder.

These views are radical, but we believe entirely sound. Tumors of the bladder are dangerous, not only on account of their local and immediate effects, but also on account of their influence upon the kidneys and their proneness to recurrence. It is rational to remove them—as Dr. Bazy advises—as early and as thoroughly as possible, and we think he makes a good point when he prefers excision to the easier methods of scraping or cauterization.

EXPULSION OF FOREIGN BODIES FROM THE ALIMENTARY CANAL.

It is now well understood that very many foreign bodies which have been swallowed will pass through the alimentary canal without giving rise to disturbance, if they are left to nature, and especially if a full vegetable diet is recommended and the use of purgatives is avoided. But it remained for Dr. Cameron, of Glasgow, to propose, for the management of cases of this sort, a formal method which is called the "potato-cure." It consists simply in getting the patient to eat large quantities of potato, which are expected to surround the foreign body and conduct it innocently through the intestines. This plan has worked admirably in a number of cases, and many foreign bodies, both sharp and of irregular form, have been successfully expelled from the alimentary canal under its working.

The subject was brought before the Royal-Imperial Society of Physicians of Vienna, January 11, 1889, and Dr. Cameron's method was warmly endorsed by several distinguished men who had tried it. The general opinion was that it might often obviate the necessity for laparotomy; and a case was reported by Dr. Hochenegg, in which by this means a foreign body had been removed in nine days precisely similar to one which had been removed by laparotomy by Prof. Albert four or five years before.

Such a showing certainly justifies calling attention to this method, although—as stated above—its underlying principles are well enough understood by most medical men.

DEATH CAUSED BY COCAINE-HABIT.

It is reported from Cincinnati that a physician of that city died recently from the effects of cocaine which he had formed the habit of taking frequently. It is said that he began experimenting with the drug a few years ago, and that he soon became a hopeless victim to its influence.

This is a sad story, and one which has a moral. Every now and then it happens that a physician becomes engaged in the toils of alcohol or a narcotic; and the result is usually the same as with men who have no medical training to protect them against delusion in such matters. Under such circumstances the spirit of kindness to the erring generally prompts those who comment on the occurrence to seek out its mitigating circumstances, and to dwell upon them, so as to shield the reputation of the victim as much as possible. This, however, we believe to be more creditable to the hearts of those who discuss so unfortunate an event than to their heads. It would be more likely to prevent the repetition of careers of this sort if a little wholesome truth followed each one. The fact is that physicians, of all men, ought to understand that it is a shame and a disgrace to yield to the seductions of stimulants or narcotics. They know, better than any other class in the community, the peril of trifling with such things, and they have no excuse for indulging a dangerous taste for them. It is probable that men who fall victims to the cocaine, or opium, or alcohol habit are men of weak will, although they may disclose their weakness only in this way. But no medical man can be excused who begins the "easy descent to Avernus," for medical men who do this sin against light; and such errors would probably be less numerous than they are, if the plain truth were told about them. The adage "*nil nisi bonum de mortuis*" has something very attractive in it; but it ought not to stand in the way of truth.

CAMPHORATED NAPHTHOL.

It has recently been found that naphthol, which is very insoluble in water, can be combined with camphor so as to form a liquid. It is only necessary to rub up one part of naphthol with two parts of dry camphor, to obtain a creamy liquid. This product is of a pinkish color if the naphthol is not pure. It has been found to be an excellent antiseptic application to wounds and ulcers, and is said to clean off the false membrane in diphtheria.

IMPOSING ON A PHYSICIAN.

It is almost incredible, but what was printed as a joke in the REPORTER some months ago has been actually put in practice in France. According to the *Gazette Hebdomadaire*, Feb. 1, 1889, a physician in a town in France was called up from his bed on a stormy winter night and implored by a peasant to come to see his child, who was suffering with an affection of the throat which threatened strangulation.

To the hesitation of the doctor to go a distance of five or six miles, he replied that he had come all the way on foot, and it was not too much to ask the doctor to go to such a desperate case. Reluctantly the doctor yielded to his sense of duty, had his carriage made ready, and then, taking his summoner with him, drove to a little village six miles away to see the patient. Arrived here, he gained access to the house with difficulty and found a child with no appearance of illness whatever. The father professed great astonishment, and protested that when he left the child it appeared about to die. With thanks to the doctor, and imitation of the symptoms of the child at an earlier hour, he allowed the physician to make his way home.

A few days later the doctor learned that just before he called him, the man had been in the town on a drinking bout, and had made a bet with a companion that he would not walk home. He won his bet at the expense of the doctor.

It is hard to believe a story of this kind, and yet it is not absolutely beyond belief. The correspondent who communicates it to the *Gazette Hebdomadaire*, couples it with another, to indicate the trials which may meet a physician in the discharge of his duty, and asks what can be done to punish those who could thus impose on the sense of duty and humanity of physicians? Some punishment a wretch of this kind ought to have; but he might better receive it from his fellows than from anyone else, for they would probably find whom the trick hurt most the next time one of them really needed medical aid at night.

The story is mainly interesting as showing that the experience of physicians is pretty much the same all the world over, and that they must expect to make certain sacrifices, for the sake of their calling, not only to the needs of their patients, but also to their ignorance or even their baseness. It is in the face of just such imposition as this story illustrates that the nobility of the medical calling shines brightest.

THE PHILADELPHIA COUNTY MEDICAL SOCIETY.—The members of the Philadelphia County Medical Society are informed that any member who has an appointment to read a paper before the Society will have it set up in type and two galley-proofs furnished him on or before the day of the meeting, provided his copy is placed in the hands of the Editor of the Transactions at least a week before the time it is to be read. This regulation must prove of great convenience to the authors of papers.

PUBLISHING LECTURES WITHOUT PERMISSION OF THE AUTHOR.—On January 7, 1889, Judge Allison made a decree in Court of Common Pleas No. 1, making perpetual the injunction which restrains Walter B. Saunders, a publisher of Philadelphia, from publishing and selling books on general and medical chemistry made up of condensations from lectures delivered at the University of Pennsylvania by Dr. Theodore G. Wormley, Professor of Chemistry and Toxicology in the Medical Department of that institution. The defendant is ordered to pay the costs of the suit. The action of the Court was based on the fact that the defendant failed to plead answer or demurrer to Dr. Wormley's bill of complaint. This decree of Judge Allison may be accepted as finally settling the question of ownership of oral lectures, and will doubtless hereafter deter anyone from publishing lectures without the owner's permission.

Book Reviews.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the Reporter.]

HANDBOOK OF THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE THROAT, NOSE AND NASO-PHARNYX. By Carl Seiler, M.D., Instructor in Laryngology and Lecturer on Diseases of the Upper Air Passages in the University of Pennsylvania, etc. Third edition, thoroughly revised, and greatly enlarged. Illustrated. Small 8vo, pp. 373. Philadelphia: Lea Brothers & Co., 1889. Price $2.25.

The fact that Dr. Seiler's manual of the diseases of the throat and nose has reached a third edition may be taken as an indication that its value as a clear and trustworthy treatise on the subject has been appreciated by the profession at large. The present edition has been fully revised so as to make it conform to the advances in laryngology during the last ten years, and it is an admirable representative of the present standing of this department of medicine. The author's style is interesting and attractive, and his book furnishes abundant evidence of his ingenuity and practical skill. It is so written as to be comprehensible to general practitioners as well as to specialists, and, indeed, it seems to be intended rather for the former than for the latter.

It is handsomely printed, abundantly illustrated, and well bound, and as a book is as creditable to the publishers as to its author.

Pamphlet Notices.

[Any reader of the Reporter who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request stating where the notice was seen and *enclosing a postage-stamp.*]

217. Functions of a School for Feeble-Minded. By A. C. Rogers, M.D., Faribault, Minn. From the *Proceedings of the Fifteenth National Convention of Charities and Correction*, July, 1888. 5 pages.

218. New Series of Metric Test-Letters and Words for Determining the Amount and Range of Accommodation. By Charles A. Oliver, M.D., Philadelphia. From the *Transactions of the Amer. Ophthalmological Society*, 1886. 3 pages.

219. Cantatory Paresis. By J. Solis-Cohen, M.D., Philadelphia. From the *Medical News*, Oct. 6, 1888. 4 pages.

220. Syphilis of the Larynx, Trachea and Bronchi. By J. Solis-Cohen, M.D., Philadelphia. From the *Transactions of the Philadelphia County Medical Society*, Sept. 12, 1888. 24 pages.

221. Inebriate Asylums and their Work. By T. D. Crothers, M.D., Hartford, Conn. 16 pages.

222. Why Electrolytic Treatment of Stricture Does Not Succeed in All Hands. By G. C. H. Meier, M.D., New York. From the *International Journal of Surgery and Antiseptics*, Oct., 1888. 18 pages.

217. Dr. Rogers's paper is one of great interest to all good citizens, and especially to medical men who have so much influence in determining the treatment of those who are sick or maimed in mind as well as in body. He regards idiots and imbeciles as practically incurable, and recommends placing them in homes where they may lead a happy, harmless and measurably useful life in assisting to care for their fellows.

218. Dr. Oliver's pamphlet is somewhat belated in coming to our table; but it deserves attention because it describes a series of tests for accommodation founded upon careful and accurate study of the conditions essential to accurate determination of the range of this function, which we believe have met the approval of other laborers in the field to which he is specially devoted.

219. Dr. Cohen describes the symptoms and treatment of a condition which is familiar to most persons who sing much, and in which attempting to make a given musical note is accompanied with a sense of weakness or even of pain.

220. This paper of Dr. Cohen's is an elaborate and able review of the subject of syphilitic manifestation in the larynx and lower breathing passages. In it the author discusses the pathology, etiology, diagnosis, prognosis and treatment of the various morbid conditions coming under the classification of his title, in a manner which might be expected from his long study and experience in diseases of this region.

221. Dr. Crothers's pamphlet contains part of a lecture delivered before the Young Men's Christian Association of Toronto, Canada, Oct. 2, 1888. It reviews the history of asylums for inebriates—which we have compunctions about calling "inebriate asylums," and makes a special plea for their usefulness and efficiency in curing the alcohol habit. As the superintendent of a well-known establishment of the kind, and as the Editor of the *Journal of Inebriety*, Dr. Crothers speaks with authority on this subject, and his pamphlet will prove interesting and suggestive to those who have the care of any of that unfortunate class for whom such institutions are provided.

222. This is another pamphlet written to defend Dr. Newman against the reflections of his critics, some of whom have classed him with charlatans, and otherwise indicated undisguised contempt for his methods. According to the old maxim: "*Audi alteram partem*," those who have not done so already might well learn what Dr. Newman and his friends have to say in regard to the comments and experiences of those who think his claims extravagant and his method worthless.

Literary Notes.

—B. Westermann & Co. announce the appearance of the *Microphotographischen Atlas der Bakterienkunde*, edited by Privatdocent Dr. C. Fraenkel and Stabsartzt Dr. R. Pfeiffer. The atlas is to appear in 12 or 15 parts, each containing 10 photograms, and costing $1.50.

—Dr. J. J. Mulheron announces in the *Medical Age*, Feb. 11, that the duties of the chair of Gynecology in the Michigan College of Medicine and Surgery, to which he has been appointed by the Trustees of that institution, added to the cares of private practice, have made it impossible for him longer to edit the *Medical Age*. Dr. B. W. Palmer succeeds Dr. Mulheron as Editor.

CORRESPONDENCE.

Are Medical Witnesses to Be Subjected to New Tests?

TO THE EDITOR.

Sir: The report of the treatment of a medical witness by an attorney in a court in Chicago, as published in the editorial in the REPORTER of February 16, calls us as physicians to be very cautious when we occupy the position of a witness. It is not probable that a respectable lawyer would imitate the conduct of the one referred to in the case reported; but a question concerning the bearing of a quotation from a medical work may be asked by a lawyer in such a way as—unintentionally to him—to lead a medical witness into error, because the attorney has mistaken the sense of the author. Some years ago, the writer was present in court when an important case was on trial. The prisoner was on trial for his life, being charged with poisoning some of his family with arsenic. His lawyer attempted the defense by taking the position "that the persons who died were affected by cholera morbus, a disease in which there are bloody stools." The following symptoms were read from a popular medical author on cholera morbus: "The vomiting and purging are almost incessant; everything taken into the stomach is promptly rejected, the discharges being often brown or blackish, acid, or even bloody." This was read to medical witness after witness, and the question asked each one: "Is the author good authority? Is it as stated?" The question specially included the supposition that bloody evacuations from the bowels were meant by the author.

The writer was not satisfied with the nature of the defence, as he had never observed bloody stools as characteristic of cholera morbus. On his return to his office, he consulted the author. On reading the quotation, it will be observed that, after the semicolon, the purging is not referred to, but the author speaks only of the vomiting. The writer repeated this to the prosecution on the following day, with the statement that the author quoted said nothing about bloody stools. The writer was then called to testify and read the passage quoted, pausing after the semicolon and saying "*semicolon*"; then read the remainder of the sentence, when the attorney said: "That is the way in which *you* read it!" "Yes," was the reply, "and so everybody reads it who reads English correctly." Nothing more was heard of the bloody stools during the trial or in the address to the jury.

The writer was called later during the trial to certify to the correctness of passages from medical writers on epilepsy, etc., etc., but he always asked for the book, that he might read the passage referred to for himself.

The moral learned from this and the late trial at Chicago is, Testify to the truth of no printed or written statement before reading it. Yours truly,

Easton, Pa., TRAILL GREEN, M.D.
February 21, 1889.

Treatment of Ichthyosis.

TO THE EDITOR.

Sir: I have a case of ichthyosis in a colored girl 8 years old. She is otherwise healthy, and has been affected with the disease three years. The whole cutaneous surface is affected, and the feet often crack so that she cannot walk. I have tried all the usual remedies without avail, or only temporary effect. I should like to ask you or the many readers of the REPORTER if there is any reliable treatment for this most troublesome affection? An answer will greatly oblige,

Yours truly,
E. I. PERSINGER, M.D.

Campti, La.,
Feb. 4, 1889.

[It is presumed, in the attempt to answer the inquiry of our correspondent, that his diagnosis is correct; although the statement that the affection began when the patient was five years old throws some doubt on that point, as the disease is usually noted at the second year. Still the error may have been in the statement of the patient.

Ichthyosis is, so far as our present knowledge goes, an incurable disease. The condition may, however, in almost all instances, be kept under control by judicious management. Internal medication is of no value, although it must be stated that the fl. ext. of jaborandi by promoting the perspiratory secretion appears in some cases to have a slightly beneficial effect. The essential treatment of the disease, however, consists in the use of baths and emollient applications. In the milder cases simple soap and hot water baths, or baths made alkaline by the addition of sodium carbonate or borax, will serve to keep the skin in a comfortable condition. After the bath, which should be taken daily or every second day, a mild ointment should be gently rubbed in. For cases of a more severe type, hot water baths with the use of sapo viridis as the soap are useful, supplemented by the application of one of the several well-known ointments advised in the text-books. An ointment especially to be recommended is one consisting of lanolin with ten to fifty grains of salicylic acid to the ounce. In those rare cases of ichthyosis hystrix, operative measures may be demanded.—Editor of the REPORTER.]

Removal of Gunpowder from the Face.

To the Editor.

Sir: In reading the Reporter of February 2, I was much interested in a communication from Dr. John Gray, having reference to the removal of gunpowder from the face. Last Fourth of July, I treated a similar case, partly by removing the individual powder-grains with a cataract-knife, partly by rubbing the face with moistened surgical gauze, but without waiting for suppuration to occur. The latter method proved, in the aggregate, less painful to the patient and more effective than the use of the knife. The result was very satisfactory, but not so perfect as in the case reported by Dr. Gray.

Yours truly,

Philadelphia, Feb. 11, 1889. A. L. Benedict, M.D.

Good Form in Professional Cards.

To the Editor.

Sir: In the Reporter, February 2, "Country Doctor" asks for a "good form" of medical card. Permit me to offer my country *confrère* the following clipping, not from the *Arizona Kicker*, but from an Arizona weekly of respectability. I do not give the name.

J. E. ——, M.D.,

PHYSICIAN AND SURGEON.

Health Officer, City of ——; for five years County Physician —— County; Medical Director Department of Arizona, G. A. R.; Late Surgeon U. S. Army; for 20 years U. S. Examining Surgeon; the largest Medical Practitioner in Arizona, and charges fees in proportion to his size. His patrons will find it to their advantage to keep healthy.

Office and Dispensary, - - —— Street,
Corner of ——,
——, - - - ARIZONA.

Yours truly,

Pellet.

—Mr. Henry C. Lea has offered to give $25,000 to the Department of Hygiene of the University of Pennsylvania, provided that an equal amount is raised from other sources.

Notes and Comments.

The Disposal of Garbage.

The Philadelphia *Ledger*, Feb. 19, 1889, states that the city of Buffalo has in practical operation a method of disposing of garbage which seems to be entirely unobjectionable, and may be made to pay more than the expenses. The system is known as "the Merz" system. The garbage is hauled to two dryers, each of which receives about 5000 pounds at one charge. Each dryer consists of a double-walled metallic cylinder, between the walls of which steam, at a pressure of about eighty pounds, circulates. Within the driers, rakes made of steam pipes revolve. These also contain steam at 80 pounds pressure; but no steam is admitted to the garbage. That which arises by the drying of the mass is carried off by means of a fan to a chamber, where it is condensed by sprays of water and passes off in an inodorous and harmless stream of water. The heat to which the garbage is subjected acts as a disinfectant, if disinfection be needed. Sixty per cent. of the weight of the garbage is thus removed as water. The dried garbage is afterward put into an extractor, which removes all the grease and oil it contains by the liberal use of benzine. The latter is used over and over again without appreciable loss.

The plant in Buffalo disposes of 30,000 pounds of garbage daily, from which about 1800 pounds of grease is recovered. The dried product is screened, and what is removed is sorted out and finds a ready sale, much of it as a fertilizer. There is only a small residuum, which has to be carted away to serve as filling.

It is said that this method of treating garbage pays a good interest on the investment required. If this is true there should not be much difficulty in having it introduced in all large cities, much to the relief of the health authorities.

At the meeting of the Board of Health Feb. 19, the committee to which had been referred the matter of the proper disposal of garbage presented a report to which was appended a resolution that "it is the opinion of the Board of Health that destruction of garbage by fire is the best plan of disposing of this waste material in the cities," and that the "department having charge of the matter be requested to adopt this method as the one best adapted to Philadelphia, and most conducive to the health and comfort of the community."

Hypodermic Injections of Ergot in Facial Neuralgia.

Dr. J. T. Stewart writes to the *Peoria Med. Monthly*, Jan., 1889, that for the relief of facial neuralgia, hypodermic injections of ergot are incomparably superior to either aconite or gelsemium. He says he has used it during the last six years and has only had it fail in one case, in which there was evidently organic disease. Ordinarily, he says, one injection relieves the pain permanently. Sometimes two, and in one very severe and obstinate case which had gone through the hands of several physicians without relief, it required three. After the third injection, the patient never had a twinge of pain. The injection was made as nearly over the seat of pain as convenient. He uses the plain extract, and has it made on purpose for hypodermic use, so that one minum represents two grains of ergot. Of this solution he uses from eight to twelve minims, blood-warm, at one injection, and without further dilution.

In order to make this treatment a success, he says two things are essential. One is, to have a fresh and pure article of ergot to make the extract from, and the other is, to have the extract reasonably fresh. If kept long, it is not only worthless, but is irritating. When properly prepared and fresh, the injection produces more or less pain for ten or fifteen minutes, and when the pain from the injection subsides the neuralgia is usually gone, and does not return.

He has also used this treatment for sciatica and other forms of neuralgia, but not with very satisfactory results.

Action of Peru Balsam in Buccal Leucoplakia.

Dr. Siegfried Rosenberg communicates to the *Therapeutische Monatshefte*, II, 10, 1888, a paper on the action of balsam of Peru upon idiopathic leucoplakia and other epithelial opacities of the mucous membrane of the mouth. He has employed it locally in different affections of the mucous membrane of the mouth and has found it good. When there is great pain and in persistent rhagades the balsam is painted on with a fine pencil, in the thick insensitive plaques with a bristle-brush, from one to three times a day. Care must be taken to have a pure, good preparation, to admonish the patient to hold the balsam some minutes in the mouth, and not to abandon the treatment too soon—especially in leucoplakia the result is at times somewhat long delayed. Dr. Rosenberg communicates a number of histories of patients, and concludes with the following words: Peru balsam acts as an anodyne in the painful affections depending upon tissue alterations of the mucous membrane; in loss of tissue it hastens skinning over and healing, and causes epithelial opacities to disappear.—*Schmidt's Jahrbücher*, Jan. 15, 1889.

Camphoric Acid in Catarrhs of Mucous Membranes.

Dr. Max Neisel states in the *Deutsche med. Wochenschrift*, XIV, 40, 1888, that he has employed, in Mosler's clinic, camphoric acid in one-half to one per cent. glycerine or alkaline solution in the form of gargles, applications made with a brush, or inhalations, and has obtained good results in slight catarrhs of the larynx, throat, and bronchi. The action of washings of a twenty per cent. alcoholic solution diluted with luke-warm water to one-half or one per cent. was especially favorable in two cases of chronic cystitis.

Given internally, camphoric acid seems to be of advantage in the night-sweats of phthisis. It may be given in capsules containing fifteen or twenty grains.—*Schmidt's Jahrbücher*, Jan. 15, 1889.

Anemone Pulsatilla in Gonorrhœal Orchitis.

Dr. Martel has employed anemone pulsatilla for some years in gonorrhœal orchitis with success. In 1885 and 1886, he reported a series of cases which he had cured with this agent, in doses of thirty drops of the tincture in twenty-four hours. The drug has the advantage of mitigating the pains and enabling the patient to walk. Dr. Bazy has taken up the experiments lately in the Hospital Midi, Paris, and communicates to the *Semaine Médicale*, No. 2, an account of forty-eight cases so treated. In thirty-five cases, recovery was complete; in ten, there was marked improvement; in two, recovery is uncertain; and in one case, the drug had no effect.

Bazy employs the drug in the following formula:

℞ Tinct. anem. pulsatillæ . . . gtt: xxx
Syrupi . . . . . f℥ iv
M. Sig. Dessertspoonful every two hours.

The remedy is willingly taken and well borne by the patients. Treatment must be continued until complete recovery occurs. The average time required for cure is eleven days.—*Wiener med. Presse*, Jan. 20, 1889.

Disagreeable Effect of Sulphonal.

Dr. J. M. Loebl writes to the *Wiener med. Presse* that his advice was sought by a woman who complained of having been affected with sleeplessness for a long time. The patient looked anæmic, but he found nothing else to account for her sleeplessness. He prescribed thirty grains of sulphonal in two doses, with the direction to take a powder in warm soup or milk one hour before bed-time. When he was called two days later he found the patient in a lamentable condition. She stated that after the first powder she did not obtain much sleep, and on the following day was somewhat deaf. In the evening she took the second powder. After a restless night, in the morning she felt intense headache, dizziness, nausea, sensations of heat and cold. Every effort to rise induced nausea. The skin was cool, the pulse 55. After the patient had taken tea and rum the pulse rose gradually to 70, though the remaining symptoms lasted the whole day and a great part of the night. On the following morning she was able for the first time to resume her household duties, though she still felt giddy. It was then learned that the patient was menstruating, and to this Dr. Loebl was inclined to attribute the whole disturbance, but the patient declared positively that she had never been so affected before, and attributed the condition to the hypnotic.

The author suggests that this case shows that sulphonal can give rise to disagreeable symptoms in some persons—probably in anæmic patients—and that it has a cumulative action.

Fatal Case of Corrosive Sublimate Poisoning After a Surgical Operation.

Professor Wilhelm Weiss communicates an account of a fatal case of corrosive sublimate poisoning after a surgical operation in the *Casopis lékaru Ceskych*, Nos. 1 and 2, 1889. At his clinic on October 19, 1888, a strong woman, 53 years old, had a lipoma weighing twenty-seven and a half pounds removed from the inner surface of the left thigh, and the wound washed with two quarts of a one per cent. corrosive sublimate solution, the wound then appearing to be covered with a fine white coating. The wound was dressed with sublimate gauze bandages. Some hours after the operation collapse and frequent vomiting of a greenish fluid occurred. In the night there were pains in the abdomen, repeated vomiting, and involuntary passage of fetid stools. Opium clysters and stimulants were administered. On the following day there were frequent evacuations with tenesmus, and collapse. Death occurred on Oct. 22, at six o'clock in the morning.

At the autopsy were found acute gangrenous inflammation of the ileum and colon as the result of corrosive sublimate poisoning; also acute parenchymatous degeneration of the kidneys. Weiss thinks that the occurrence of poisoning in this, as well as in most of the cases of corrosive sublimate poisoning occurring in surgical operations, must be attributed to a special idiosyncrasy toward mercury; and he mentions a case seen by him in which, after a single insufflation of a small quantity of calomel, violent stomatitis and other pronounced symptoms of poisoning had occurred. He regards the inflammation of the ileum and colon in corrosive sublimate poisoning as conditions secondary to the primary parenchymatous nephritis, and therefore urges the necessity of being assured before every surgical application of corrosive sublimate that the kidneys are perfectly healthy.—*Wiener med. Presse*, Jan. 20, 1889.

Eschscholtzia Californica: a New Hypnotic.

Ter-Zakariantz speaks highly in the *Semaine Médicale*, No. 52, of a new hypnotic—eschscholtzia californica. It belongs to the family of the papaveraceæ, and he declares it to be both a valuable hypnotic and a very useful anodyne, and, being harmless, preferable to morphine. It can be administered in the form of a potion, of a syrup, or in pills in daily doses of thirty-seven and a half to one hundred and fifty grains. Several formulæ are given by him.—*Wiener med. Presse*, Jan. 6, 1889.

Munificent Gift to the Presbyterian Hospital.

Mr. John H. Converse has about perfected arrangements for the erection of a building, to be given by him to the Presbyterian Hospital, of Philadelphia. This intended gift was referred to in the REPORTER, Feb. 16, p. 215.

The new structure is to be called the Administration building, and will cost between $60,000 and $70,000. It will be an ornamental structure of stone and brick, and will be supplied with all the improvements adapted to a building of the kind. It will be four stories high with a large basement. In the basement there will be offices,

dining rooms for servants, kitchens, pantries, etc. The first floor will contain the office of the superintendent, a surgical clinic room, operating rooms, an apothecary shop, a room for the meetings of the Board of Trustees and the offices of the physicians in charge of the hospital. The second, third and fourth floors will contain the various sleeping apartments for the physicians and nurses.

The Minnesota Medical Act.

Dr. Perry H. Millard, of St. Paul, Minn., writes to the *Journal of the Amer. Med. Association*, Feb. 2, 1889, concerning the work accomplished by the State Board of Medical Examiners of Minnesota in the brief period of its existence, working under the provisions of the present State Medical Practice Act. The statistics are presented with the hope that they may direct the attention of the profession anew to the benefit to be derived, by both the public and profession, from efficient medical legislation, and trusting that they may further stimulate the profession in securing, at the hands of the respective legislatures, now in session, such legislation as is required to protect both the public and the profession. The present Act regulating the practice of medicine in Minnesota, became operative, July 1, 1887, and succeeded the old Act that had been in successful operation for a period of four and a half years. The old Act was a verbatim copy of the present Illinois Act, excepting that the exemption clause was five years instead of ten, which is the period of exemption of the Illinois Act. Through the operations of the old Act the profession of the State had experienced some of the benefits of medical legislation, and was therefore disposed to aid and support the present Act in every way possible. The Minnesota Act has been enforced in a quiet, conscientious and determined manner, by a board composed of the leading representative men of the profession of the State. The Act has received no mention by the medical press of the country, notwithstanding the fact that it is the best Act in existence in any State, and is as ably enforced as any of the various State Medical Acts. The present board has held seven quarterly meetings, at which eighty-six physicians have applied to be examined. Of this number six were refused admission to the class, not having taken three full courses of medical lectures of six months duration each. Of the eighty entering the various examinations, fifty-one were licensed. Some of this number underwent several quarterly examinations before being successful. Twenty-nine were rejected, not possessing the knowledge of medicine required by the board. Of those who passed, forty-nine are Regulars and two Homœopaths. Of those failing to pass the examination, eighteen were Regulars, eight were Homœopaths, and only three were electic physicians. Those passing the examinations of the board were mostly graduates of McGill, Harvard, Chicago Medical, and the University of Michigan. Students who were graduates of the two-term schools and those having sessions of less than six months duration, are of course prohibited the privilege of practice in the State.

American Medical Association.

The Fortieth Annual Meeting of the Association will be held in Newport, R. I., June 25, 1889, under the Presidency of W. W. Dawson, M.D., of Cincinnati, Ohio.

The Chairman of the Committee of Arrangements is H. R. Storer, M.D., of Newport, R. I.

Those who intend to read papers are requested to send word as soon as possible to the chairman of the proper section. The sections and officers are as follows:

Practice of Medicine, etc.—F. C. Shattuck, Boston, Mass., Chairman; G. A. Fackler, Cincinnati, O., Secretary.

Surgery and Anatomy.—N. P. Dandridge, Cincinnati, O., Chairman; W. O. Roberts, Louisville, Ky., Secretary.

Obstetrics and Diseases of Women.—W. H. Wathen, Louisville, Ky., Chairman; A. B. Carpenter, Cleveland, O., Secretary.

State Medicine.—J. Berrien Lindsley, Nashville, Tenn., Chairman; S. T. Armstrong, U. S. Marine Hospital, New York, Secretary.

Ophthalmology.—Geo. E. Frothingham, Ann Arbor, Mich., Chairman; G. C. Savage, Nashville, Tenn., Secretary.

Laryngology and Otology.—W. H. Daly, Pittsburgh, Pa., Chairman; E. Fletcher Ingals, Chicago, Ill., Secretary.

Diseases of Children.—J. A. Larrabee, Louisville, Ky., Chairman; C. J. Jennings, Detroit, Mich., Secretary.

Medical Jurisprudence. — W. Kiernan, Chicago, Ill., Chairman; T. C. Evans, Baltimore, Md., Secretary.

Dermatology and Syphilography.—L. Duncan Bulkley, N. Y., Chairman; W. T. Corlett, Cleveland, Ohio, Secretary.

Oral and Dental Surgery.—F. H. Rehwinkle, Chillicothe, O., Chairman; E. S. Talbot, Chicago, Ill., Secretary.

NEWS.

—The Swedish government has permitted cremation under certain medical and clerical restrictions.

—Fifteen hundred physicians attended the third Russian Medical Congress held at St. Petersburg Jan. 15.

—Hiram Vandusen, of New York City, asserts that he has lived for sixty-five days on Vichy and Croton water.

—The will of the late Alexander Murray, of Montreal, bequeaths to the Montreal General Hospital the sum of $750,000.

—The son of Dr. Jacoby, a boy 11 years old, was recently cremated in Paris. This is the first cremation that has taken place there.

—The *Lancet*, Feb. 9, announces that Dr. H. Frémy has been sent by the French Government to Colorado to study its climate.

—The Moral Reform Union of England has been exerting its influence to prevent the employment of children of a school age at theatres.

—The deaths in Philadelphia for the week ending Feb. 23, numbered 347. There were 11 deaths from scarlet fever, 18 from typhoid fever, and 7 from diphtheria.

—The *Lancet*, Feb. 16, says the Russian Government has found it necessary to issue a regulation forbidding female medical practitioners to attend adults of the male sex.

—Dr. William Pepper, Provost of the University of Pennsylvania has announced that during the coming year it is proposed to put up a dormitory building for the accommodation of the University students.

—The *British Med. Journal*, Feb. 9, states that Dr. Fancourt Barnes's "Manual of Midwifery for Midwives" has been translated into Burmese by order of those in charge of the Countess of Dufferin's Fund.

—An extensive epidemic of a scarlatinal character is said by the *Lancet*, Feb. 16, to prevail in and around Macclesfield. Upward of a hundred cases have already occurred, and some deaths have been reported. The milk supply is suspected to be the source of the poison.

—A state vaccine institute has been established in Italy by Royal decree. It will be under the direction of the Department of Public Health and of the Ministry of the Interior. The Committee of Management consists of Professor L. Pagliani, Dr. Felice Baroffio, and Prof. Davide Toscani.

HUMOR.

IT IS DOUBTLESS A KNOWLEDGE of the fact that every one can see through it that causes the window pane.—*Life.*

NEEDED A CHANGE.—Doctor—"What your husband needs, Madam, is change of scene."

Mrs. De Temper—"Do you think he should go off for his health?"

"Well, it doesn't matter which goes—you or he."

"THE EDITOR down the street," writes a Kansas editor, with withering scorn, "should go to school during the winter months, so that the teacher can learn him something about grammar. We have seen bad writers before, but we never seen one who could crowd so many grammatical erratum into a single sentence."—*Kansas City Star.*

A WISE MEDICINE MAN.—Dr. Ebbonie—"Dat chile o' yours am lookin' poo'ly, Mrs. Yallerby. What's he done gone an' swallowed this time?"

Mrs. Yallerby—"A bit ob lead-pencil, docto'."

Dr. Ebbonie—"H'm! What he wants now, ma'am, am an erasive remedy. I recommend him ter chew a piece ob Injy-rubber half an hour afore each meal."—*Puck.*

A PLACARD placed on the window of a shoemaker's shop near Cripplegate, London, many years ago, is said to have read as follows:

Surgery
performed on aged
Boots and Shoes
broken Legs sett and bound upright
disordered feet repaired
the wounded heeld,
The whole Constitution mended
and the Body supported
by
a new Sole. By T. T.

OBITUARY.

WILLIAM WEIGHTMAN, JR., M.D.

Dr. William Weightman, Jr., died at his residence, Falls of Schuylkill, Feb. 10. Dr. Weightman was born in Philadelphia October 10, 1845. After a thorough school education he studied medicine at the University of Pennsylvania, from which he was graduated with honors. Immediately after graduating he entered the employ of Powers & Weightman, manufacturing chemists, and was admitted into the firm in 1884, soon afterward taking charge of the works at the Falls of Schuylkill.